PUBLIC HEALTH NURSING

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PUBLIC HEALTH NURSING

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Courtesy American Forests

We wish for all our readers a vacation filled with happy, restful days

THE 1935 SAUNDERS MEDAL

Adda Eldredge

To Adda Eldredge in recognition of her "unique contribution as official administrator of the state function of control of nursing education in Wisconsin" has been awarded the Walter Burns Saunders Memorial Medal for 1935. This medal is awarded yearly for "distinguished service in the cause of nursing" and was presented to Miss Eldredge at the convention banquet of the National League of Nursing Education in New York City, June 5, by Dr. C.-E. A. Winslow of Yale University. Dr. Winslow said in part:

"It is sometimes said that the vocation of the teacher is a peculiarly unselfish one. The teacher, however, has the keen and direct satisfaction of seeing individual pupils grow and develop under his eye. Far more remote, far more unselfish, is the work of the official who labors so that the teacher may have the opportunity to do her work. Very vicarious are the satisfactions to be derived from a service of this kind; very immediate are its difficulties and its discouragements. . . . The capstone of selflessness is the labor of the public official who makes it easier for the teacher to educate the nurse. It is for unique distinction in this field that we honor Miss Eldredge tonight."

SCURVY

Pediatricians are calling attention to a definite and disturbing appearance of scurvy among infants of the indigent and near-indigent class. In one city in Michigan as many as 17 grave cases appeared within four months. More impressive teaching regarding the use of orange and tomato juices for infants and preschool children is needed, stressing with the parents the importance of buying these foods before money is spent on far less important things—tobacco and coffee, for instance. The baby's diet is so limited that the omission of fruit juices even for a few weeks may cause irreparable harm. Vitamin C in orange, tomato, grapefruit or pineapple juices or in crushed ripe bananas must be present in the diet as a protection against scurvy. Public health nurses are urged never to leave a home in which there are children under five without being assured that the mother understands and is actually *carrying out* this vital dietary precaution.

THE INDIAN HEALTH SERVICE

A recent report by Joseph W. Mountin, Surgeon, and J. G. Townsend, Senior Surgeon of the U. S. Public Health Service, gives a vivid story of Indian Health problems. Before the advent of the white man, the vitality of the Indians was marvelous. But the white man conquered the Indian not only with guns, but with infectious disease. Measles, whooping cough, comparatively harmless for white people are virulent among Indians; on the other hand, heart and liver disease, cancer, insanity, and nervous disorders are rather rare. However, ignorance, poverty and the low standard of living among the present-day Indians have caused high infant and tuberculosis death rates—and the scourge of trachoma. To combat these conditions, the Indian Health Service is doing everything it can. The service has been greatly expanded in the last ten years and the health problems of the Indians are being somewhat eased by the construction of additional hospitals with PWA funds.

An Adventure in Learning

An Account of the Educational Program for ERA Nurses in Indiana

By VIRGINIA A. JONES, R.N.

Assistant Director, Bureau of Public Health Nursing, Indiana State Division of Public Health

WHAT would you have done if suddenly overnight several hundred CWSA (later ERA) nurses were set down in your state to do public health nursing? The problem would have been comparatively simple in Indiana had these nurses been placed with established public health nursing organizations, but most of them were placed in counties where there were no other nurses working in public health and, in many instances, never had been. Their communities were as inexperienced as they.

And O, what we needed to know about these nurses and their communities! With what kind of personalities were we dealing? Many of these nurses we had never heard of before because they previously had not taken the bother even to register in the state. What were their attitudes toward public health? Would it be just a job or an opportunity? Would they realize that they were not qualified public health nurses? Only six of the whole group had had previous training and experience in public health and there was no opportunity to choose nurses because of their particular aptitude for or previous successful experience in this type of work. How did these nurses feel toward supervision, toward taking some of their own time to learn about their jobs? What would their reactions be to a group of their colleagues? How able would they be to profit from the ideas of others? What were the common problems of the group? What did they need most to know?

How did the communities feel about it all? Did they see the opportunity for building toward a permanent service? Would they expect to employ these unqualified nurses for permanent positions? (Only the requirements for school nurses are set by regulation in Indiana.)

How would the other FERA workers in the community fit into the program —(social workers, works director, etc.)? How would the community (the lay advisory committees representing the supporting organizations) feel about making it possible for the nurse to get help from regular group conferences, where adjustment of program, and sometimes transportation, must be provided for?

Of course, the six advisory nurses who were visiting these nurses in the field had learned a great deal about them and had given them much, but their visits, possibly only once in three or four weeks, were neither frequent enough nor long enough to give to all the help needed so badly. The nurses' monthly reports at this stage of the game told us very little.

WE CONDUCT INSTITUTES

The story of what we decided to do and how—namely to conduct a series of one-day conferences in each of the six advisory nurses' districts, has been told.* This article will describe the institutes in more detail and discuss some of their accomplishments.

The first of the series of five institutes aimed to orient the nurse in her job. We discussed informally the principles of public health nursing, its general objectives; the relationship of the nurse to her committee and volunteers, the relationship of other organizations in a community health program, and very definitely did we outline the organization of

*PUBLIC HEALTH NURSING, December, 1934, p. 659; *American Journal of Nursing*, December, 1934, p. 1158.

a lay advisory committee because that was set up by the state advisory nursing committee as a requirement for each ERA nursing service.

The other four institutes centered on the work at hand. We were on the verge of a summer program with schools out and the nurse left without that fixed institution around which to build her activities. So we planned programs, demonstrated procedures and discussed problems of the preschool round-up, follow-up visits for school defects, prenatal and maternity care, communicable diseases, including syphilis and gonorrhea, sanitation, tuberculosis and adult health education. With the help of the advisory nurse, each nurse outlined on paper at the fifth institute the services which seemed most desirable for her to undertake, decided on her objectives (very few and simple) for the year and outlined her activities to carry out the objectives. June and July gave the nurses time to work out their programs.

In August, just before the opening of school, the school program had to be planned, so the two institutes held then centered around that.

In November we studied the nurses' monthly reports to find what their most pressing problems were. It seemed that the nurse's own adaptation to her environment needed stressing so we discussed the importance of mental health, using as a basis the problems which the nurses themselves indicated they wished assistance with, and referring to Morgan's "Keeping a Sound Mind"* for practical help in each problem. Another pressing problem was teaching the mother with the relief order or the low income to buy and prepare the family food supply. This we also discussed, trying to find local food products which were cheap to substitute for other foods which cost more. Other problems discussed were nursery schools, (ERA nurses had been asked to make the morning inspections of the children in these schools), control of scabies, pediculosis and impetigo.

The institutes held in January and February stressed techniques and procedures again with demonstrations of bag technique, vision and hearing testing, and the inspection of the school child. Each nurse brought her improvised bag for inspection. The details of prenatal instruction were discussed.

In April attendance at the two-day annual meeting of the Indiana State Tuberculosis Association in Indianapolis served for an institute. ERA nurses attended one day on their own time, one day on duty time. Many county tuberculosis associations paid all or part of the expenses of the ERA nurses in their communities. The next series will be based upon the needs as felt by the advisory nurses and the monthly reports of the nurses themselves.

An effort was made to make each meeting as informal as possible. We tried to bring out points which could be challenged by the nurses in order to stimulate discussion. The ERA nurses gave the demonstrations, using their own initiative and ideas, knowing that they would be freely criticized by the group. We found in these demonstrations much dramatic talent which heretofore had lain hidden. Frequent rest periods were given. Visitors and lay people were invited to attend and were introduced. It became quite a contest to see which nurse could bring the most nursing committee members from her county. Some time was always left for the nurses to describe their own programs, interesting accomplishments, devices they were using, special activities and perplexing problems. And the nurses certainly took advantage of it.

Here is the analysis of attendance at the 32 institutes:

ERA nurses	1005
Regular public health nurses	126
Other nurses (institutional, private duty and students)	54
Health officers and physicians	21
Public health nursing board and committee members	99
Superintendents of schools	10
Teachers	7
P.T.A. officers	2
Tuberculosis Association secretaries	30
Secretaries of Red Cross Chapters	11
Home Demonstration agents	2
Attendance officers	4

*The Macmillan Company, New York.

County ERA works directors	7
ERA case supervisors	10
Township trustees	2
Mayors	2
Others	34

WHAT DID THE NURSES THINK?

Just after the first institutes the following appeared in the narrative report of one ERA nurse with its counterpart in many other reports:

"Having had no experience in public health nursing, I have taken advantage of this opportunity and I am glad to say it has been an experience. My first few weeks were rather inefficient ones because we had no rules or orders. Now with the suggestions I get from my institutes, I feel I am doing my work more efficiently."

And this from an experienced public health nurse—now on ERA:

"I have enjoyed our institutes immensely. I thought they might be more or less of a bore and felt that on account of the distance I had to travel each time, it would be a legitimate excuse not to attend, but they have been so very interesting and instructive that I look forward each week to the next institute."

DID THE SUGGESTIONS CARRY OVER?

Following the institutes on committee organization and program planning reports like these come in from practically all the services:

"A meeting of the Central Nursing Committee of this county brought about its organization with the appointment of a sub-committee for transportation and supplies for the nurse, and publicity. At the next meeting a report will be given on a survey of the needs of the county by one of the committee members. The program to be carried on along with the school work will depend upon the report."

"My schedule is so arranged that I will visit each school twice a month. On our first visit to a school we will make rapid classroom inspections in each room. On our future visits we will inspect the beginners and those referred by parents or teachers. In the afternoons we are making home calls in the district where we do inspections in the forenoon. In making these home calls I find tuberculosis patients and prenatal cases which I care for right away."

And this:

"These are my objectives for my rural schools for this coming year:

1. Set up a properly equipped first aid cabinet in each school.
2. Teach teachers to be responsible for first aid and emergencies.
3. Teach teachers to make daily inspections for symptoms of communicable disease.
4. Inspect children referred by teachers or parents, first graders, and new children.
5. Follow-up of those inspected.
6. Care for one outstanding need in each school (toilets, hand-washing facilities, hot lunches, ventilation, etc.)
7. Organize health committee in each school or P.T.A."

And then after the institute on procedures:

"On July 5th my state advisory nurse was here. I had my bag, daily reports, and past records for her to see."

This report from a rural ERA nurse shows that the discussion on planning the family's food supply at the November institute carried over.

"The social case supervisor for our county and I got together and made out market lists and menus for our families on relief so that they could get the most and best food for the money which they were allowed."

WHAT THE COMMITTEE MEMBERS SAY

One committee member, a busy county superintendent of schools, brought his ERA nurse 120 miles to one institute to see if it was worth the expense to the committee. "I'm fully convinced now," he said at the institute, "of the importance and value of such meetings. We'll send our nurse and come with her whenever we can."

Perhaps the most gratifying result of this educational program came when one ERA nurse, asked by an official to apply for a political appointment as city board of health nurse, replied "I am not qualified." The requests for information regarding summer courses in public health nursing now coming in indicate that other ERA nurses also feel the need of more preparation.

WHAT DID WE LEARN?

The discussions brought out the common and most frequent problems that the nurses met in the field, giving us a basis for the institute programs. The problems which for lack of time could not be brought up at the meetings were discussed in our bimonthly bulletin *Echoes*.

In addition we were gratified to see:

That these nurses were hungry for new experiences which were opening up a whole new field to them, the results of which they would take back into their institutional and private duty nursing.

That the time was not only not begrudged for the institutes but in most instances the desire was expressed for more frequent meetings.

That such meetings with committee members and other lay workers stimulated community planning and agency coöperation.

That the carry-over of the discussions was unexpectedly good.

That the efficiency reports compiled by the advisory nurses showed progressive improvement in the individual nurses.

That the regularly employed public health nurses in communities both urban and rural were stimulated to analyze and reappraise their programs and procedures.

What we had feared would be a chaos of public health nursing activities, unethical procedures, haphazard programs and permanent placements of unqualified nurses has resulted rather in well-planned programs, approved activities, sufficiently uniform procedures and techniques and a realization by the nurses and committee members that special preparation is necessary for public health nurses. This was due, we feel, to the heroic work of the seven advisory nurses supplemented by the institute program and the bulletins and mimeographed material sent out by the State Bureau of Public Health Nursing, with the ever ready help, publicity, and encouragement of the Indiana State Nurses' Association, the Indiana State Board of Registration and Examination of Nurses, the Indiana State Tuberculosis Association, the N.O.P.H.N., and the American National Red Cross.

FORTY-FIRST ANNUAL CONVENTION OF THE NATIONAL LEAGUE OF NURSING EDUCATION

THE FORTY-FIRST annual convention of the National League of Nursing Education in New York City, June 3-8, was one of the most successful that the League has ever had, successful not only in numbers attending—over 1,200—but in the unusual interest of the papers presented and the discussion aroused. Because of the revision that is going on at the present time of the "Curriculum for Schools of Nursing" many of the sessions were devoted to a discussion of the changes needed in the nursing school curriculum. Should the curriculum be kept purely professional, or should a general educational program be included, either paralleling or fused with the professional? Should certain subjects be made prerequisites for entering a school of nursing? How can our teaching methods be improved? What is the place of affiliations in the scheme? These are but some of the many important questions upon which leaders from the educational and nursing fields attempted to throw light.

One of the high spots of the Convention was the seventy-fifth anniversary meeting of the founding of Florence Nightingale's school, St. Thomas', in London, which was held in Carnegie Hall. The delightful informality of the greetings presented by Miss Nutting, Mrs. August Belmont, and Dr. John Finley, the thought-provoking address by Dr. William Kilpatrick on "The Educational Challenge" and the haunting loveliness of the singing of the Westminster Choir, made it a delightful and memorable occasion.

A State-Wide Infantile Paralysis Program

By LILLIAN E. KRON, R.N.

Nurse in Charge of Poliomyelitis After-Care, State Department of Public Health, Vermont

THREE hundred and six cases of infantile paralysis in one season in the sparsely settled state of Vermont led to the formation of a very worth-while and successful plan for the after-care of the victims of this disease, on a state-wide basis.

The history of infantile paralysis in Vermont dates from 1894 when the first known epidemic of any considerable size in the United States occurred. Of the one hundred and thirty-two cases on which data were collected all but eight occurred in one valley which is only about thirty miles long and twelve to fifteen miles wide including the sides of the mountain ranges. During the epidemic domestic animals in this region were also stricken with an acute nervous disease which often paralyzed them and frequently caused death.

The year 1914 is a memorable one in infantile paralysis history in Vermont not only because our severest epidemic occurred then, but because that was the year that infantile paralysis research and after-care became established as a part of the State health program. Three hundred and six people, most of whom were children, were stricken with this most dreaded disease. Fifty-three died.

The necessity of attempting to prevent recurrences of such epidemics and also of preventing deformities and disability in those already stricken, was seen by those who were interested in this comparatively new disease. The result was that a large sum of money was given anonymously to the State Board of Health by a very generous citizen of the State for the purpose of conducting an educational campaign, for research work, and for specialized after-care treatment of the paralyzed cases.

THROUGH CLINICS

Treatment of such a large number of cases was a difficult problem. Attempting to see the patients individually in their own homes or in doctors' offices seemed futile, so plans were made to hold clinics in five centers of the State which would best accommodate the greatest number of cases. The physicians were notified of these clinics and they in turn, notified their patients. Restricted activity, massage and muscle reëducation when all muscle tenderness had disappeared, and braces were prescribed by the orthopedic specialist who conducted the clinics. Exercises were planned for each individual case by the physiotherapist who assisted him.

That first series of free public clinics for infantile paralysis victims in this country was held twenty years ago last December. The work has been continued without interruption since that time excepting for a period of a few months during the war. That interruption served to prove the value of the work and the necessity for resuming this service as a part of the State health program, for during that interval of nine months requests were continually being received at the State Board of Health for assistance and advice; braces needed repairs or were outgrown; old deformities were increasing; new deformities were developing and acute cases were in need of immediate care. Patients were discouraged because of the interruption and the uncertainty of the continuation of their care worried them or their parents. The work was reorganized in May 1919 following the same general plan which, since its beginning in 1914, became widely known as "The Vermont Plan."

"THE VERMONT PLAN"

Our "polio" after-care division is composed of four workers—two nurses who are also physiotherapists; a handicraft instructor and a secretary. We work not only with the new cases which crop

up each year, but also with those of long standing. The cases are kept under supervision, regardless of age or the year of onset, as long as we can be of help to them. Our patients are scattered over the length and breadth of the State —in the hill towns and valley towns; and on mountain-side, valley and hill-top farms. We cannot always get to them by car but have to be met at the nearest village or at the cross-roads by old Dobbin and a sleigh or buckboard, depending upon whether it is the season of snow or mud. If the distance is not too great we walk.

When a new case of infantile paralysis is reported to the State Board of Health, we communicate with the patient's doctor. If he wants our help with after-care, a call is made on the patient and the mother or some other responsible person is instructed in the immediate care. Deformities develop easily, so whenever necessary, splints are applied to prevent contractures of the stronger muscles and stretching of the weaker ones. No massage or muscle reëducation is commenced until all muscle tenderness has entirely disappeared. Warm salt water baths help to relieve this tenderness and are recommended when the patient has recovered sufficiently so that he can be lifted from his bed to the tub without too much discomfort. In some cases the tenderness is of short duration while in other cases it may continue for months.

When the tenderness has finally disappeared a thorough muscle examination is made; the power of individual muscles is graded; exercises for the affected ones are planned accordingly, and taught to the mother. When paralysis is extensive or when the patient with less involvement appears to have a good chance of recovering practically normal muscle function if activity is restricted, we attempt to keep him in bed for a long period of time.

All patients do not need braces but when they are required, we take the measurements for them, have them made, and fit them to make sure that they are comfortable, well-fitting, and that they will accomplish the purpose for which they were made.

Some of the cases make excellent recoveries; others require surgery—after a long period of muscle reëducation—to make them more independent; while in other cases muscle recovery has been so slight that surgery would be of no particular benefit and the patient has to continue to wear one and sometimes two braces the rest of his life.

It is surprising how little braces and crutches handicap some people. Two brothers had "polio" when they were about four and six years of age; both wear two braces which come to the hips and they walk with the aid of crutches. In spite of this encumbrance they are conducting a successful hardware, plumbing and steam-fitting business. I could cite many other cases which show a great deal of courage, integrity and ambition but space is limited.

Two or three series of clinics are held during the year in eight centers in the State. The spring and fall clinics are held by us, the two nurses, for inspection of braces; muscle examinations and revision of exercises. The summer clinics—which are of the greatest importance—are conducted by an orthopedic specialist. At these clinics treatment of various kinds is prescribed. Two additional physiotherapists are employed to assist with muscle examinations and the planning and teaching of exercises.

Follow-up home visits are made on the urgent cases for supervision of their treatment. When surgery has been recommended the purpose and the nature of the operation are carefully explained. If the patient (or parents in the case of a child) wishes to have the operation performed, we make the arrangements for hospitalization and frequently find it necessary to bring the patients to the hospitals.

When patients are discharged from the hospitals, we make home visits to advise and assist with the post-operative care. This care consists principally of the removal of casts and instructing some responsible member of the family how to give the exercises which are so very important after a muscle transplant.

Operations which are performed and which are beneficial are muscle trans-

plants in the thumb, wrist, elbow, shoulder, foot, knee and hip; Hoke stabilization of the foot; leg lengthening; spinal fusion and in some cases arthrodesis of the knee.

It is indeed gratifying to see patients improve so as to be able to discard braces of various kinds, plaster turnbuckle jackets, high cork soles, crutches or canes—as a result either of the return of muscle power, or of surgery, and sometimes a combination of the two.

The handicraft work is conducted principally for those patients who are so badly handicapped that they are unable to do any other kind of work. Beautiful needle work, hand weaving, hooking of rugs, knitting, chair seating, woodwork and other arts are taught to the patients. The finished articles are sold at gift shops and at sales held at summer hotels. The sale price minus the cost of the material is paid to the patients.

NOW A STATE SUPPORTED PROJECT

From 1914 to 1933 this work was financed by an anonymous donor who, because of her interest and generosity, made the project possible in the beginning and continued to do so for nineteen years. She then found it necessary to discontinue her support, not because of lack of interest but because of financial conditions. When the State Legislature convened two years ago, money was appropriated for the continuation of this work. The appropriation, however, was not sufficient but it has been supplemented by generous gifts from another friend who is interested in this particular kind of work.

The purpose of our work is evident: We strive to make our patients as physically independent as is possible and do what we can to encourage them and help them to become self-supporting and useful citizens instead of liabilities to society.

Every normal person desires to be of use and to be able to make a contribution to humanity. This desire is just as great and probably greater in a physically handicapped person and it is a privilege to be a help in the fulfillment of these desires.

LEADING ARTICLES IN THE AMERICAN JOURNAL OF NURSING FOR JULY 1935

A Solution for the Diaper Problem

By RUTH HOWARD SAYERS
Walpole, Mass.

TO find either romance or mystery in exploring the field of diapers could hardly be expected. Nothing, I suppose, is quite so unromantic as a diaper. But to believe that "human interest" features and new discoveries would be lacking would be equally mistaken. I found both—and in sizable amounts.

A mother who, when questioned about diapers, replied resignedly, "Oh, diapers are diapers!" expressed the general attitude for many, many years toward these unimaginative but necessary articles. Hers was the typical point of view, that diapers are more or less a necessary evil, a burden to be stoically borne by every mother and child. And because of this attitude, babies have continued to be uncomfortably and unhealthily bundled into thick, heavy diapers, or have been straight-jacketed into a diaper too small for any but pygmy offspring.

It seemed not to occur to anyone that improvements might be made, that there is always something new to be learned about the obvious if you look at it from a fresh and unprejudiced point of view, until an entirely new fabric was produced by a company which made hospital surgical dressings. This fabric was made of two layers of lightweight cotton material woven together at the selvage to make flat, smooth edges. It was light and porous yet more absorbent, had no rough hems or uncomfortable bulkiness, and its ease of washing and quick drying removed most of the burden of diaper washing.

At last the question of a proper diaper material was answered. But there was still something to be learned. Obviously, regardless of how absorbent or how lacking in bulk a material might be, it still could be too bulky or too little absorbent depending on how much of it were used. Therefore, sizes and folding methods were important—and there seemed to be ninety and nine shapes and sizes of diapers and almost as many ways of folding them!

Into this "chaos" of diaper sizes and folds I was plunged, for the sole purpose of discovering what, specifically, was the most satisfactory diaper size in actual use and how should it be folded. Six months later I emerged with the 19″ x 40″ (shrunk) size and the new "panel" fold. Chaos may seem a strong word, but after I had made an exhaustive review of sizes recommended in the most widely-read books and pamphlets on infant care, published by pediatricians and child health organizations, no other word seemed appropriate. Hardly any two authorities agreed (several were flatly contradictory) and the sizes recommended as "best" actually varied from 18″ x 18″ to 27″ x 54″! Stores, slightly more consistent, concentrated in the East on the 20″ x 40″ oblong, in the West on the 27″ x 27″ square.

The first step of the investigation was to find out what measurements a diaper must meet from beginning to end of the diaper period. Because the essential statistics on waist and thigh measurements seemed nowhere available, I enlisted the aid of several hospitals and numerous individual mothers and collected them personally by the simple expedient of using a tape-measure. My models were aged from two weeks to two years and included a complete range between the corpulent and the scrawny.

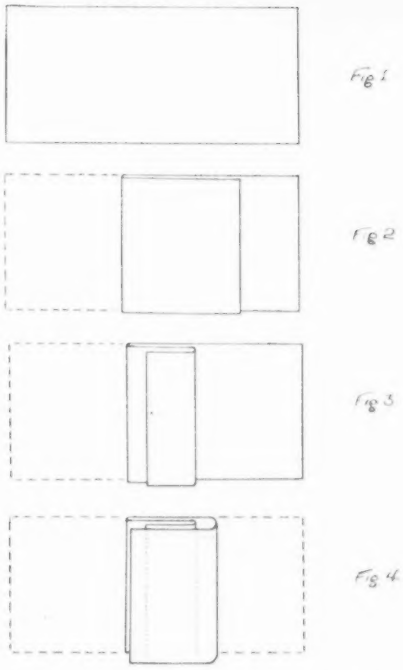
These measurements served as a basis for studying shapes and sizes. Folding methods, too, entered the picture, for a diaper becomes an article of clothing only after being folded. There are ready-made diapers which need no folding, but they have the disadvantage of slow drying (because they cannot be opened out) and their lack of adaptabil-

ity in size (because they are already made up) usually makes it necessary to buy two sizes or two sets of diapers, an expensive procedure.

Study of sizes and shapes was based on three considerations: protection, or the number of folded thicknesses; adjustability, in meeting the baby's changing measurements; and convenience of folding, for few mothers will use a complicated fold regularly. I soon discovered that the small sizes are completely useless after a few months (or even weeks) and hence a waste of money. The sometimes recommended plan of buying two dozen each of a small and a large size also proved impractical. Actually, the entire four dozen will almost invariably be used regularly. The large ones will be much too large at first, then the small ones will become too small and have to be replaced. The plan of buying small sizes with the idea of continuing their use by later using two at once likewise was found unsatisfactory.

It was interesting to find that the oblong fold was first introduced in the East by foreigners. Its superiority to the old triangle fold (for which the 27″ x 27″ was widely used) was evident and it was ideally suited to an oblong shape diaper. As adoption of the new fold spread, preference changed from square to oblong shape, gradually establishing the 20″ x 40″, and the old 27″ x 27″ square has now been discontinued and almost forgotten by many Eastern stores. Now the oblong fold is in general use throughout the country, and I expect that in time the oblong shape diaper will entirely replace the square, as it has already done in the East. But progress is slow. In large sections of the country the oblong shape is still unknown. Yet it is unquestionably more satisfactory in every respect.

The new panel fold was probably the most interesting development of my study of folding methods. In efforts to adjust various folds to fit larger babies, I hit upon an entirely new idea, providing a center panel of extra thickness. A 20″ x 40″ diaper (Fig. 1) folded as



shown gives about a 12″ width, the maximum needed by the average child during the diaper period. One end is brought over about 8″ from the other (Fig. 2), then folded back 2″ to 3″ from the folded edge (Fig. 3). The other end is then brought over to this outside folded edge (Fig. 4) completely covering the center panel. Dotted lines in Fig. 4 indicate the four-thickness panel in the center, where protection is needed. It is put on like the regular oblong fold, of course, and its advantages are many:

1. It makes it possible to have the protection of four thicknesses during the entire period. The lack of logic in the present practice of making diapers fit by reducing the number of thicknesses as the child grows older should be obvious!

2. It can be adapted to fit any size baby by varying the width of the panel. Both small and large adjustments are easily made.

3. Since the extra material is placed in the center, the side areas are less bulky, therefore less apt to cause chafing. This also makes pinning easier, a feature not to be overlooked!

4. It is economical. Only one size or one set of diapers is needed for the entire period, nor is it the largest and most expensive.

5. It is smooth against the baby's skin, has no folds or ridges.

6. It is simple and can be easily folded after very little practice.

The final step of determining what specific measurements make the best diaper size was a very straight-forward proposition. I had ample statistics on what measurements a folded diaper must meet during the diaper period and I felt fully qualified for a diploma on folding methods. Allowances for pinning, etc., were made and everything was based on shrunk measurements since they alone are practical. No two materials shrink alike.

A 19″ x 40″ shrunk size would, I found, answer all questions and meet all requirements. This is very close to the present 20″ x 40″ size, particularly in the new diaper material. By folding the length in fourths for perhaps the first six months, then using the panel fold, it can be used most satisfactorily for the entire diaper period. Still avoiding too much "theory," I tested this size thoroughly on various of my many-sized models, whose patience must have been fast nearing an end. The mothers were pleased and satisfied. If the models objected, they were too polite to say so.

The conclusions reached in this study were presented to many leading pediatricians, who almost unanimously confessed that their acquaintance with the diaper problem was somewhat remote (as, of course, there was reason to suspect!) The results have also been welcomed by many organizations interested in child care. With the additional cooperation of the nursing profession, the present hodge-podge diaper situation should one day be a thing of the past, and the 19″ x 40″ shrunk size known and used everywhere as the standard size diaper.

Pioneer Maternity and Child Welfare Work in Rural Singapore, 1927-1934

By I. M. M. SIMMONS, S.R.S., H.V.D.
Matron, Maternity and Child Welfare, Rural Singapore

SINGAPORE, one of the three Settlements which form the Crown Colony of British Malaya, has an area of about 218 square miles. It lies to the South of the Malay Peninsula very near the equator but in spite of this the temperature rarely rises above 90° F. by day and falls to about 80° F. at night. The absence of any well-defined cold season and the great humidity of the climate cause it to be rather enervating to Europeans.

Very extensive and successful work has been done to control the spread of malaria. Even in the rural parts of the island, Singapore, compared with other tropical countries, occupies a most favorable position in regard to health conditions. There still remain, however, many preventable causes of disease and death.

In February, 1927, I arrived in the Colony to begin a campaign of infant welfare work in the rural parts of Singapore, an area of about 200 square miles with a scattered population of 557,745, chiefly squatters, comprising Malays, Javanese, Boanese, Tamils, Bengalis, Sihks, Arabs, Chinese, and Eurasians. The infant mortality rate, judged by Western standards was appallingly high —262.3 per 1,000 births. This high rate was not so much due to poverty as to ignorance and the religious and racial customs of the various peoples inhabiting the island. Malay girls are kept in ignorance of much that they should know before they are married at the early age of twelve or thirteen. Their first baby, usually born when the mother is fourteen or fifteen years old, is at once taken complete possession of by

the grandmother; a yearly succession of babies follows, and it is no uncommon thing to find that out of a family of nine or ten only four, three, two, or often none have survived.

Malay women have many customs which are injurious to their own and their infants' health, customs for which they have no other explanation than "Malay people always do it." They have a favorite proverb which says, "Destroy our children but not our customs." Also they accept no responsibility for anything which may happen, "Tuan Allah Suka"—"the will of God"—they say when a baby dies in convulsions, after a diet of rice, bananas and coffee.

The Chinese also have their superstitions and taboos in regard to the newborn infant: light, fresh air, sunshine, and the use of water are considered by the Chinese grandmother to be harmful during the early months of life. I have found many Chinese babies who had never been outside their dark cubicles before they were four or five months old; also many three or four months old who had never been bathed since their birthday bath.

TYPES OF DWELLINGS

The rural population consists chiefly of squatters who build their houses of the materials at hand. The Malay people prefer to live on the edge of the sea or river, or over a swamp in houses built on piles. As a rule the only furnishings are mats of native make and many brightly colored cushions; everyone sits, eats, and sleeps on the floor. The houses are light and airy. The Chinese squatter builds a low wooden hut with gabled roof, frequently destitute of windows or any aperture except the low doorway to provide light and air. There may be only one single room with one or more tiny cubicles curtained off, which even at noontide of a tropical day may be quite dark. The outer room is chiefly occupied by a large wood fire and cooking pots, numerous fowls and ducks, and sometimes a sow and her litter. The floors of the huts are often of mud or loose dirty sand, over which scramble hens, ducks, chickens, puppies, and babies, various of them sharing a common bowl of rice.

I once found a Chinese baby sucking his milk from a large black bottle through a tube quite a yard in length. I gave the mother a Nestle feeder with a short hygienic nipple, and demonstrated with the baby how to use it.

Traveling Dispensary—Asiatic doctor is examining child, author on steps

She was quite pleased until she saw me carrying away the tube bottle and then exclaimed, "Yes, mem, the baby may be able to suck from your new bottle but what will the pig do?" and lifting a large inverted rattan-basket she displayed a young sucking pig which was being fattened up for the Chinese New Year festival. Needless to say the long-tube bottle was left for piggie!

WORK IN THE KAMPONGS

For the first two years the work was practically all done in the kampongs or on the roadside. Each district was visited either weekly or fortnightly. Birth

reports were collected from all the rural police stations en route and efforts made to find each newborn child. In the early days we were often unsuccessful in tracing all the children whose births had been registered, but we always found many others whose fathers had not reported the birth. The addresses given at the police stations were very vague, the homes scattered in plantations, kampongs and jungle; perhaps two or three miles inside or up a steep jungle covered hill. Sometimes after a long hot search I would find the baby had been given away, or if the mother were a Malay, she and her infant might have returned to some distant kampong, only having come to her parents' home for the birth of her child.

A great stumbling block was the variety of languages in use; the majority of Chinese squatters neither understand nor speak Malay. Chinese from different parts of China do not speak a common language. Javanese and Boanese speak a different dialect of Malay; Tamils, Bengalis, Japanese speak other tongues.

Health visiting in the kampongs brought to light numerous cases of post-puerperal beriberi, particularly among Malay women. Many infants and children were found to be suffering from neglected scalds, burns, ulcers, and a variety of skin diseases, suppurating eyes and ears. Nearly every child over one year was suffering from worms, and consequently coughs, fevers, anaemia and general debility. Numbers of young infants were found tightly wrapped in heavy clothing and kept in dark airless cubicles for the first few months of their lives, fed often on inferior brands of preserved milk flavored with coffee. Many of these children had rickets.

One of the most important achievements is to have persuaded the Chinese grandmothers that sunshine, fresh air, and a daily bath will cause no harm to the youngest infant; also that the five or six thickly padded coats, necessary in China at some seasons of the year, are never needed in Malaya.

In Singapore Town there are all the resources of a large modern general hospital, a maternity hospital where the poor of any race can obtain free treatment, and also food acceptable to their particular race or creed. In 1927 the kampong folk made no use of this; now after several years' work among them they are more willing to go. Usually I take them in my car, otherwise by the time the ambulance arrives their courage has failed.

TRAVELLING DISPENSARY

Finding so many sick people in the kampongs made it evident that a broad view must be taken of the health work and the scope widened to include the family as a unit. This was made possible through coöperation with the Government Travelling Dispensary, also a pioneer effort to take medical help to sick in outlying districts. The motor-dispensary was equipped with all necessary drugs and dressings; carried a doctor, a graduate of the local medical school; also an experienced dresser, who in addition to English, spoke Malay, Tamil and some Chinese.

WAYSIDE CLINICS

For the first two years in addition to visiting all the newborn infants, I made house-to-house visits, taking the same route as the Travelling Dispensary, which waited at agreed places on the roadside while I went into the kampongs. Anyone, man, woman or child, needing treatment was given a card and sent out to the Travelling Dispensary. If the patient was too ill to go, a parent or friend would be sent with a card requesting the doctor to visit the home.

The newborn infant, however, has been the "key" which has unlocked every home. House-to-house visits became unnecessary—people knew which day to expect us; fathers waited at police stations to take us to their babies; groups of mothers and children waited at intervals along the roadside beneath the shade of a tree for Sister's weekly inspection.

As at this time the majority of women received no skilled help at their confinements, it was essential to give some nursing care to the mothers and babies

on the first visits. It has been this practical help which has been so effective in gaining the confidence of the mothers and grandmothers, the latter the most important member in a Chinese family.

Useful as these wayside clinics were, it was possible to do more effective educational work at a center, where the mothers could meet one another, compare their babies, and have a chat.

WORK AT THE CENTERS

By March, 1933, six years after the beginning of the welfare campaign, there was a maternity and child welfare center in each of the five sanitary districts of rural Singapore; a branch, one at a rural dispensary, and another on an island some miles from Singapore—seven centers altogether.

The centers are converted shophouses, the lower rooms are used for waiting and clinic rooms, the flat above provides living quarters for the health nurse, midwife, and attendant. The nurses and midwives are Chinese women locally trained; they are kind, patient and excellent teachers. The district of each nurse is about 35 to 40 square miles. She is responsible for visiting all newborn, preschool children, antenatal and postnatal cases within that radius; she is also "on call" alternate Sundays with the midwife. Every Chinese or Indian mother is asked to bring her baby to the center when it is one month old, Malay babies after 44 days.

The center midwife is "on call" for the same district to attend any poor women in their confinement. She attends her cases for ten days unless transport is too difficult or the case too far away. On the last two visits the mother must bathe the baby under the midwife's supervision. In 1934, 1,140 confinements were attended by these center midwives; formerly all these mothers would have been left to the care of their husbands or neighbors during their confinements, many babies subsequently dying from tetanus or asphyxia, the mothers in danger of haemorrhage or sepsis. Most of these mothers attended a center during their pregnancy.

A clinic is held at each center twice a week. It is possible to keep one day for well babies and another for toddlers and infants needing treatment. The babies attend from one month old for weighing, examination and advice. In the early days we were not allowed to remove clothes or touch the children with water; now that is all changed and every infant is stripped, clothes placed in an individual basket, the baby is laid on a couch and thoroughly examined together with its clothes. Babies are weighed at each visit and the mothers praised for their success or advised. Now only strangers come with long-tube feeders, comforters, or unbathed babies. The "regulars" are spick and span, bathed, and in clean clothes.

ACTIVITIES AT THE CENTERS

Demonstrations are given of preparing formulas, storing and cleaning feeders; making and cutting of suitable garments, for which patterns are lent; short individual talks are given also and demonstrations of essential elementary health habits. Minor ailments are treated and first aid given to emergency cases. Private midwives attend to report their cases and have their baskets examined.

REGISTRATION OF MIDWIVES

Registration and supervision of midwives was the natural development of the infant welfare work. In January, 1930, the midwives ordinance was extended to include the rural area. All practicing midwives were required to register and to report all births attended by them within 24 hours. Existing untrained Bidans or midwives were allowed a certain period in which to register provided they attended a center to be instructed in the midwives' rules, and used the lined baskets provided for them. No midwife can be registered now unless she has had 9 months' training in the hospital and holds the certificate of Central Midwives' Board.

The purposes of the work are primarily educational and preventive; treatments are incidental to this end. Parents are beginning to regard the centers as health centers where they come

for help and advice in keeping healthy children healthy, not as at first—dispensaries for sick children.

All elaborate equipment is avoided, efficiency with economy is the aim. Demonstrations are given as far as possible with things the mothers can have in their own homes. A few grains of uncooked rice will clean a feeder effectively and more safely than a bottle brush which is likely to be dirty. An empty milk can makes a useful measure; clean rags answer many purposes where wool or lint might be used, soap and water instead of ointments. Diets that we know the mother cannot provide are never advised. All the homes are visited so the economic conditions are known, the mothers are encouraged to make the best use of their own resources, to use foods that their own kampongs can provide. Well-mashed bananas take the place of barley or oatflour, pineapple or papya juice instead of orange juice, a few drops of raw egg yolk added to the feeding of a bottle-fed baby. Teeth can be cleaned Indian fashion with a piece of soft fibrous wood. A home-made play-pen will prevent a child from worm infestation and sores caused by playing on ground polluted by pigs, ducks and fowls.

WHAT HAS BEEN ACHIEVED IN SEVEN YEARS

1. Six maternity and child welfare centers in rural Singapore.
2. A health nurse, locally trained in general nursing and midwifery, at five of the centers.
3. An Asiatic qualified midwife in residence at each center to attend any poor woman in confinement and nurse her for ten days.
4. Four Malay women trained in midwifery to replace untrained Malay "bidans" in the kampongs.
5. A reduction in the infant mortality rate in six years from 262.3 per thousand in 1927, to 172 per thousand in 1931, 160 per thousand in 1932.
6. All practicing midwives registered and supervised. No more untrained women allowed to practice as midwives.
7. Free maternity service for any poor mother.
8. Clinics for well babies and toddlers, for sick babies and mothers and children, for antenatal and postnatal cases, for infant vaccinations.

Work on similar lines is being carried on by British Sisters in the two other Straits Settlements where the population is chiefly Malay.

Headquarters: An Office in this Building

The Negro Nurse in a Tuberculosis Program *

By FANNIE ESHLEMAN, R.N.

The Henry Phipps Institute, University of Pennsylvania

SINCE the beginning of the anti-tuberculosis movement in the latter part of the nineteenth century there has been a steady decline in the death rate from this disease, in which the organized campaign has played an important part whatever may be the more obscure factors also at work. Recently the officials of the Metropolitan Life Insurance Company have estimated that between 1930 and 1933 tuberculosis mortality in the United States decreased by 16.2 per cent. They characterized this gain as "the outstanding public health achievement of modern times." There is one section of the population however—the Negro race—that has not shared proportionately in this advance. It is well known that this group is more susceptible to tuberculosis than the white population, and that tuberculosis more often runs an acute course and more often ends fatally. The morbidity rate is in fact four or five times that among whites, and in Philadelphia in 1933, the colored population, 11 per cent of the whole, contributed 34 per cent of the tuberculosis mortality. Such figures show that special efforts must be made to meet this problem, both from a humanitarian concern with the individual patient, and from the community interest in stopping up wells of infection.

Some three decades ago the Henry Phipps Institute was opened in Philadelphia for the study, treatment and prevention of tuberculosis. During the earlier period of the Institute's history, it was found impossible to do satisfactory work with Negro patients. Those who came to the clinic, more or less by accident, could seldom be induced to persist in their attendance and no considerable progress could be made with them as individuals. Moreover, the educational effort, which at that time served to bring increasing numbers of white patients to the clinic, had not perceptibly increased the interest of Negroes in their health. Clinic reports show that during the first ten years about one hundred Negroes were cared for yearly, although the Institute was located in a section of the city with many colored residents.

In 1913 Dr. H. R. M. Landis, Director of the Clinical and Sociological Departments, decided that something should be done since the machinery in operation was ineffective. It occurred to him that where the white doctor and white nurse had failed the Negro doctor and Negro nurse might succeed. He felt that their knowledge and sympathetic understanding of their people's points of view might draw the Negroes to the dispensary for advice. On February 1, 1914, a colored nurse reported for duty, her salary being paid by the Whittier Center, a society organized for the betterment of the Negro race. This nurse's work was so successful during the first year that at the beginning of the second year a Negro physician was employed. From then on, other physicians and nurses were added to the staff, and by February, 1926, there were employed 16 physicians and 10 nurses. Besides the clinic at the Institute, three others had been opened. These clinics, devoted in whole or in part to Negro health work, became known as the Negro Bureau, with its medical and nursing work supervised by the staff of the clinical and sociological departments of the Phipps Institute.

WORK MADE POSSIBLE THROUGH SEAL SALE

The development of the Negro work has been made possible through funds

*Read before the Regional Conference of the National Association of Colored Graduate Nurses at the Mercy Hospital, Philadelphia, February 2, 1935.

supplied by the Philadelphia Health Council and Tuberculosis Committee. This is the local tuberculosis association of Philadelphia County, and it raises its budget through the sale of Christmas Seals. From 1923 to 1934 the Health Council spent $270,302 for this Negro program. The largest yearly amount expended was $29,000 in 1931.

In 1926, after the project had been in operation twelve years, Dr. Landis reported that as a result of these twelve years' experience, the following conclusions were justifiable:

1. The use of Negro nurses has made it possible to reach the Negroes. Prior to the employment of these nurses, the Negroes did not avail themselves of the medical advantages offered. As a means of imparting health education in the home and bringing individuals to the dispensary the Negro nurse has been an unqualified success.

2. This work has been done by nurses with but little public health training. What knowledge they have of the subject has been obtained by practical work at the Institute before making them independently responsible. A very urgent need is the provision of means to enable these Negro nurses to take a qualified course in public health nursing.

3. The weak link in the plan at present is the difficulty in obtaining adequate Negro physicians. If the Negro is to obtain the full benefit of modern hygiene, it is essential that the medical members of his own race be properly equipped.

4. For a time the feeling was entertained that it would be possible, eventually, to turn the entire responsibility of the work over to the Negroes themselves. This idea has been abandoned for the present at least. They still need guidance.

It may be noted that a somewhat similar experiment in the South has failed because the entire project has been placed at once in the hands of an inexperienced Negro staff. It is clear that training, advice, and general direction can be given advantageously by an institution that has long been engaged in studying and dealing with this particular highly specialized medical and nursing problem.

INSTRUCTING STUDENTS

Shortly after Dr. Landis had employed the first Negro nurse he was anxious to institute a program to give the Negro nurse preparation in tuberculosis work, particularly from a public health point of view. The dispensary organization of the Institute provided chest clinics for adults and for children of school and preschool age. There was in operation a prenatal and gynecological service, a syphilis clinic, a nose and throat clinic, and recently a pneumothorax clinic has been established. With tuberculosis, venereal disease, infant and maternity mortality said to be the leading health problems of the Negro there was thus at the Institute a "set-up" for instruction in all these fields. In November, 1921, the School of Nursing, Mercy Hospital, Philadelphia, a hospital owned and operated by Negroes, accepted an offer of the Institute to give instruction to their students, and it made arrangements to send their senior nurses for two months' field experience. This period of field instruction, with its emphasis on health teaching as applied to tuberculosis, by its very nature also teaches public health nursing in its broadest sense. Early in 1922, in order that these students might have visiting nurse experience, the foundation of public health nursing, help was solicited from the department of public health nursing of the Pennsylvania School of Social Work. A plan was worked out by which students matriculating in this department could have the two months' affiliation with the Phipps Institute and the Visiting Nurse Society, subsequently receiving a certificate from the School attesting to this four months' field experience. The plan was a satisfactory one, and when the course in public health nursing was suspended, the Mercy Hospital School of Nursing retained its affiliation with the Institute and the Society. Since November 1921, when the first undergraduate began this training, to December 31, 1934, 77 students have received the two months' instruction at the Institute.

The program as presented to the undergraduate at the Institute today is outlined briefly below.

PROGRAM OF STUDY

1. *Objective*

   To instruct student nurses in tuberculosis as a public health problem.

2. *Content of Instruction*
   a. Case finding. In public health nursing, this consists chiefly in watching closely for symptoms, particularly early symptoms, in the clinic and in every home visited, and in seeing that all those with a history of contact with tuberculosis come to the clinic for examination.
   b. Care of the tuberculosis patient—home and institutional.
   c. Prevention of tuberculosis. This includes the teaching of hygienic principles to the patient and his family, search for all sources of contagion, periodic examinations and supervision of those in contact with the disease.
   d. Social service and health care. The nurse is directly concerned with all factors affecting the nutrition and general welfare of the family, as is essential in treatment and prevention of tuberculosis. She must be familiar with the means of rehabilitation of the patient and his family and in touch with the agencies concerned.
   e. History taking and observations in clinic and home. The nurse must know how to obtain, with tact and accuracy, the pertinent information required in the medical and nursing care of tuberculosis.

3. *Program of Experience*
   a. First two weeks with clinic nurse
      1. Housekeeping of clinics
      2. Preparation of patients for clinic:
         Temperature — pulse — respiration — weight—height
      3. Attendance with patients in following clinics:
         Chest—adults, school and preschool children
         X-ray
         Pneumothorax
         Nose and throat
         Prenatal and gynecological
      4. Instruction of patients regarding:
         Function of clinics—care of sputum—collection of sputum—return clinic visits
      5. Laboratory tests
         Examination of sputum
         Tuberculin test
         Sedimentation
   b. Six weeks with Field Nurse
      1. History taking
      2. Interviews with patients in dispensary
      3. Preparation for home visits
      4. Home visits
      5. Contacts with social agencies
      6. Records — daily report — report of home visit
      7. Visiting to Tuberculosis Ward of the Philadelphia General Hospital
   c. Conferences
      1. Nurses monthly staff conference
      2. Clinical — pathological conference twice a month
      3. Weekly conference with supervisor
   d. Notebook and required readings.

Undergraduate nurse from the School of Nursing, Mercy Hospital, ready for field work at the Henry Phipps Institute

In 1930 a survey of Negro public health nursing showed a fairly general disinclination on the part of nurses to take up postgraduate studies. The reason for this is perhaps expressed by the comment of a group of nurses in one of the largest cities studied: Why should we spend money on professional meetings and professional courses when there are no opportunities to advance?

Reviewing the records of the 77 undergraduates, a few of whom had the four months' affiliation, the others two months at the Phipps Institute, it was learned that 22 of these young women subsequently found positions in public health nursing. None of them had had any other experience in public health nursing or any special preparation in this field as graduate nurses.

In any consideration of educational qualifications one must also take into

account all the more intangible factors, which in any worker can be measured only by her general attitude and intelligence. These personal attributes will be reflected constantly in the public health nurse's reactions and judgment in the various situations she is called upon to meet in her community. Having the foundation, however, it is necessary to build upon it. Public health nursing and tuberculosis work as specialized fields with highly developed technics, and an adequate training in the essentials of the work to be done are as important as general aptitude.

Realizing the limited opportunities Negro nurses have for obtaining field experience we offered last year to the School of Nursing of the Mercy Hospital, the privilege of sending annually one of its graduates interested in public health nursing for one year's experience at the Institute. The nurse is paid a monthly salary, a third of which is retained each month until the twelve months have expired. This sum is then returned to the nurse to be used in further postgraduate work in public health nursing. The Henry Phipps Institute is desirous of making its organization available for instruction and field experience for Negro and white nurses from all sections of the country who are interested in tuberculosis as a public health problem.

The Negro Bureau in Philadelphia today consists of two clinics. Reductions in clinic centers and personnel have had to be made because of an insufficient budget, which, as has been stated, is supplied largely by the Philadelphia Health Council through the sale of Christmas Seals. There are now eight physicians and nine nurses on the staff, one of the nurses acting in the capacity of field supervisor. The 1930 census showed that there has been an increase in the Negro population of Philadelphia of 63.6 per cent since 1920, while the white population increased but 2.4 per cent. In 1933 there were reported* in Philadelphia 1,378 deaths from tuberculosis, of which 475 were among Negroes. The work with Negroes accomplished in 1934 may be summarized as follows:

Patients cared for	3,263
Visits to Clinics by patients	14,345
Visits of Nurses to families	5,145
Individual services rendered	19,323
Tuberculous patients cared for	330
Families of tuberculous patients supervised	293

As with white patients, the medical, nursing and record work of these clinics is planned for on a household basis. A diagnosis of tuberculosis indicates care for the patient and examinations for other members of his family. Repeated examinations of the patient's sputum are made, as the type of instruction given by the nurse depends on the continuing danger of contagion, of which a positive sputum is conclusive evidence. Not only is the nurse interested in the care of the patient and members of his family but she is concerned with finding all sources of contagion. Though tuberculosis usually originates through long continued daily contact with an open, that is, a sputum-positive case, in the home, this may occur in the shop, school or through other outside associations. As long as the patient remains at home the nurse must see that the strictest hygiene is maintained to stop all further spread of contagion. The nurse will also by her expert advice help the family to maintain the good living conditions necessary in the treatment and prevention of tuberculosis. In this very intimate family relationship it is the colored nurse with her understanding and sympathy who holds the key to success of this health work among her people. As one supervisor said, "Negro people will not tell everything to the white nurse." The Negro nurse, as pointed out in the study of Negro public health nursing, is able to gain the confidence of her people without reservations and understands how to overcome the peculiar superstitions of the more ignorant among them. White supervisors have found that this psychological advantage is the first essential of constructive work with the race.**

*Wiesner, D. E.: Tuberculosis in Philadelphia, The Philadelphia Health Council and Tuberculosis Committee.

**Rayfield, S., Stimson, M., Tattershall, L. M.: A study of Negro public health nursing, *Public Health Nurse,* October, 1930, p. 525.

A Curative Playroom for Crippled Children

By HENRIETTA W. McNARY

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TO play, to laugh, and to develop according to each one's mental and physical endowment are the inherent rights of every child born in a civilized community. It is to build upon what life has given and yet failed to give. The Curative Playroom maintained by the Association for the Crippled and Disabled endeavors to offer a treatment program for the crippled child of preschool age or one not eligible to attend Cleveland's well equipped schools for crippled children. After leaving the hospital the same treatment is carried out under the supervision of the doctor, who issues a new prescription.

The program of the Curative Playroom is not school work but embraces this three-fold purpose:

First, to provide physical development of the child's body following disease, injury or developmental malformation. Weak muscles are strengthened, limited joint motion is increased, and faulty coördination is improved by carefully directed exercise.

Second, to direct habit training, a term which best covers the efforts of teaching the child adequately to care for himself. This includes dressing himself, eating, personal care and speech training. The last mentioned needs a great deal of time and special teacher.

Third, to offer a normal atmosphere of play and learning so arranged that the child can successfully partake of all its phases. Both the child and parent must be taught a sane attitude toward the handicap. Intelligent consideration without over-protection is essential to normal development of character.

The general types of disabilities benefited by the program of the Curative Playroom are:

Congenital disabilities
- Birth injuries
- Spastic paralysis
- Malformation

Disease
- Poliomyelitis
- Arthritis—infrequent
- Encephalitis

Trauma
- Fractures
- Burns—extensive scar tissue
- Nerve injuries

Admittance is not limited to children of normal or high intelligence quotient. A poor mental endowment unquestionably retards progress. As it is difficult to secure a true evaluation of intelligence due to the child's inability to express himself, all types are admitted for a trial period of six months. If after this time has elapsed, the child does not show sufficient improvement to warrant further effort, discharge is recommended. The mother is encouraged to carry on the work at home.

To better understand the program it will be necessary to take up the procedure in some detail. After hospital discharge or other medical care, the doctor refers the child to the Curative Playroom as a treatment clinic. He is

Drawing on the blackboard is exercise for the shoulder muscles. The sling with the balance weight (shown behind the instructor's head) eliminates the weight of the arm so a very weak muscle can lift the arm and receive exercise through normal motion

asked to fill out a blank giving detailed diagnosis and prescription with cautions to be observed, as well as operative and X-ray reports, prognosis and date of next examination. Furthermore, it is essential to determine if a hearing or sight difficulty is present and likely to interfere with training. If so, special medical attention is sought. Each child is given a psychometric and performance test at the Child Guidance Clinic. The results of these tests are used as guides in the training program, but it is understood that they are not infallible

On admission, the patient's condition is carefully analyzed to determine whether the physical disability is caused by muscle weakness, joint limitation, faulty coördination or a combination of these possibilities. Detail of treatment is then worked out. The division falls logically into physical therapy and occupational therapy.

Physical therapy offers as treatment heat and massage for general nutrition of the part by stimulating circulation. This is followed by specific muscle training on a table to strengthen and encourage active muscle pull. The child must be taught the sensation of function of non-used or partially used muscle groups before he can be expected to employ the paralyzed muscles in purposeful use. Natural compensation teaches him to avoid the use of the impaired part and to carry on with greater ease but marked awkwardness. This must be avoided during treatment to assure maximum gain in function. Gentle stretching of limited joints is directed to release adhesions and secure greater range of motion. Posture and gait are analysed by the physical therapist, and with the aid of mirrors correction is sought. If further postural exercises are indicated they will be included.

Through occupational therapy treatment further muscle training and coordination are carried out translating exercise into purposeful action. This is procured through play, the child's realm of activity. Toys and games are analyzed and adapted to meet the specific needs of each child, then presented to him in so engaging a manner as to bring forth his enthusiastic efforts to actively use the impaired part. It must be a game he can play with success and supplement his own imagination. Be it selling fish, extinguishing a fire, or building London bridge, he must be whole-heartedly engrossed but placed in circumstances that call for the exact exercises listed as treatment. As improvement is shown the play becomes more complex or more strenuous to keep pace with the child's ability.

BUILDING THROUGH PLAY

Here are listed the toys most frequently used for strength and rhythm exercises. Kiddy cars without and with pedals, small and large velocipedes, and a bicycle saw with adjustable pedals and seat supports offer any combination of hip, knee and ankle exercise in the anterior-posterior plane for children of various ages. Lower arm and hand treatment is met by use of peg boards and blocks for finger flexion and general precision, snapping and spinning games for finger extension and thumb opposition, hammer boards and pegs for wrist and elbow involvement, screwing toys for forearm pronation and supination, and

a sand-box where analyzed play can meet almost any lower arm exercise. Shoulder exercise is given largely by play at a toy fish-pond or drawing on a blackboard where forward flexion, abduction and rotation in and out are determined by the child's position and the direction of lines drawn. When shoulder muscles are too weak to raise the arm alone, it is supported in a sling to which counter-balance weights are attached and assist muscle pull. Imaginative games are used for exercise of muscles difficult otherwise to bring into play. Example: "Thumpkin says toes out, . . . in," for hip rotation. Rhythmic play to music is invaluable to summon coordination. The music must be carefully selected to give marked rhythm and melody enough to prevent monotony. Such records are put out by the R.C.A. Victor Company, Inc., *Rhythms for Children*. All toys used are now on the commercial market, many of them under the name of educational toys.

A child must learn to care for himself. To learn to feed oneself and dress oneself is a great tonic. The process may be long and tedious but if it is broken into a series of simple elements, the child can master one at a time and feel the glow of success en route. Buttons, lacings and ties are tackled by use of a board to which are attached two pieces of material to be joined by these fastenings. When this is mastered the acquired skill is transferred direct to clothes and shoes. Likewise eating practice proceeds without food, using dishes set into a base. When actual food is handled assistance is necessary to prevent the child from accidentally tossing it about when muscle spasm occurs. He later learns to handle it alone. All this sort of activity is individual.

GROUP WORK

Occupational therapy also includes group work to bring into the program the socializing element. Here general preschool and kindergarten activities are undertaken. The children learn the general give and take of life. An every-body-ante philosophy is encouraged. Each child has a part to play in the group project. He is a distinct entity and in his time he must stand alone in the spotlight. One child may have to be encouraged and cautiously led into

the center of things and another may have to be gradually tempered and taught graciously to wait his turn. Many of these children have been unwisely indulged or kept in oblivious corners for shame. The change to a normal relationship must be gradually brought about.

Through case work the coöperation of the family is sought and the program interpreted at home. A background must be prepared for the child's development by seeing that proper food, clothing, sleeping conditions, etc., are provided. When domestic rift and misunderstanding interfere with progress the social worker attempts to relieve the situation.

Records are kept to evaluate progress and redirect the procedure if necessary. Manual muscle tests and joint measurements are periodically reported. Height and weight are measured monthly. A behavior rating chart is attempted. Ten essential elements of behavior are listed and graded at four-week intervals, and efforts are directed toward developing those qualities showing low ratings. A

statement of treatment and progress is sent to his respective doctor each time a child returns for check-up. The intervals vary from two weeks to several months, depending on the case. The complete record is open at all times to the referring doctor or clinic.

The proximate location of the brace shop enables close check on brace fitting and repair. Although prescription for the brace comes directly from the doctor, minor alignments and repairs are quickly secured.

The Association for the Crippled and Disabled is an independent organization partially supported by the Community Fund and partially by earnings and endowment. It cares for full-pay, part-pay and non-pay cases. The organization is controlled by a board of trustees who invest administrative power in an executive secretary and well trained staff. The medical policies are governed by a board of medical advisors appointed by the Academy of Medicine. The Curative Playroom is but a part of the entire program which includes physical and occupational therapy for adults in the curative workshop and homes as well as sheltered employment both in shop and home. The former is strictly therapeutic while the latter is economic in purpose. A social service department and general examination by a staff physician are available to all clients. The patients referred for treatment remain in the care of the referring doctor.

To secure a full treatment program as early in life as possible assures better results and adjustment to the residual disability.

UNIVERSITY OF MINNESOTA RAISES STANDARDS

THE BACHELOR OF SCIENCE degree becomes the goal for preparation for public health nursing in the University of Minnesota. Public health nursing students matriculating in the University for the first time in the fall of 1935 will not receive a certificate in public health nursing; they will be candidates for the degree with a major in public health nursing, a program requiring approximately three years of study. This work can be taken at broken intervals if the student so wishes. Students who have matriculated in the University prior to the fall of 1935, and who are candidates for the certificate in public health nursing, may claim the certificate if the requirements are met prior to the fall of 1940.

Changing Views with Changing Seats

By THEDA L. WATERMAN, R.N.

Supervisor of Clinics, Cook County Hospital, Chicago, Ill.

THERE is an old and oft' used saying that goes something like this: it all depends upon where you sit how you see the show. I think that, without doubt, no other phrase so aptly describes my experiences with clinics. Until about a year ago, I was working in the public health nursing field, and as part of the usual routine I escorted many patients to and through various clinics. I was, so to speak, on the outside looking in. My chief interest in any clinic was in the kind and amount of service it could render my patients. The several problems of the clinic did not concern me. But now, I have changed my seat in the clinic show and I find the view very different. This time I am on the inside looking out. As a supervisor of clinics, my concern is not for just a few patients, but for the care of many patients and the teaching of nurses as well. There are many problems and responsibilities undreamed of before, and I find myself forced to change many of my pet ideas and opinions.

It was my experience during the years I spent in active field work, to be always situated at some distance from the clinical centers where my patients were served. To secure service for them meant that I must drive them to clinics, a trip of from twenty-five to thirty-five miles depending where my patients lived. Because of the cost of the trip in time and car expense I always planned to take several patients each time I went. A clinic visit was therefore usually an all-day affair and often an exhausting experience. To reach a morning clinic I had to rise with the dawn and start forth to collect my passengers, who often lived miles apart. This in itself was time-consuming but when one added the annoyance of delays due to patients not being up or dressed, the whole preliminary trip was apt to be exasperating.

Never will I forget the feeling of arriving at clinic, all out of breath, with from three to five wide-eyed, scared and bewildered children clutching at my arms and pockets, to be coolly greeted by a calm, white starched personification of efficiency who asked, "Nurse, can't you try to get here earlier?"

Once safely inside we sat on the benches and waited until histories were taken and my charges assigned to their several doctors. From then on all went smoothly except for the fidgeting and the squirming of the children. And then at last, after all the children had been seen by the doctors, there would be my conference with the nurse as to how best to carry out the doctor's instructions, trying to act intelligent and professional and at the same time keep an eye on the five adventurous spirits who now relieved of fears were beginning to explore. Not until all were safely deposited in the "flivver" could I draw a deep breath.

From all of these experiences "on the outside" I gathered one impression: The seemingly detached and calm manner of the nurses which always gave me a slight feeling of inferiority, even of awe. I think I always wondered why clinic routine was so cumbersome and impersonal. After the first trip to any of the clinics it was always easier because I was known and the difficulties attached to my trip were understood and appreciated. Then every effort was made to make my stay as short as possible. One clinic served milk to the children before they started on the long drive home. But in spite of all the kindness and understanding I hesitated to ask to be taken out of turn or to seem to expect any unusual favors just because I was a nurse.

ON THE INSIDE

Now my position is changed and I see things from a different angle. I know how necessary it is for all patients to be registered on time, because many times one clinic must close promptly to make way for another one later in the day. I know the doctors are usually anxious to get away to other appointments. I can appreciate that under the strain of caring for so many patients day after day it is difficult to have a personal and interested attitude in each patient. Not many nurses realize that the aim of the clinic is often twofold: Caring for the patient and at the same time teaching doctors and nurses. Each aim is important and this makes for a doubleheaded program that is sometimes quite difficult to keep balanced. It cannot be said that one is more important than the other because they are so dependent upon each other. The head nurse in the clinic is a hostess, yes, but sometimes, under the pressure of circumstances such as crowds and confusion, she becomes a very casual hostess. Too often her attention and time become so concentrated upon the routine of clinic work and the teaching of student nurses that she seems indifferent to the other phases of clinic activity. The nurse or patient coming in from the outside cannot be expected to understand this, unless the clinic nurse herself can with tact and diplomacy make it clear.

Also, I now see that often the slightest irregularity of routine or the suggestion of special attention looms very large to the already heavily burdened clinic nurse. Many times she knows of others who need this special attention just as much as does the patient accompanied by a nurse. It may be a mother who has traveled miles on a street car with her child or another mother who has left a baby at home with an older child, or a woman who has left her work and must return at a certain time or lose her job.

REMEDIES

If the nurse could notify the clinic when she is bringing patients so that the service could be anticipated and planned for, it would make no difficulty whatever, but instead would lead to a greater satisfaction to every one concerned. If in some way a mutual understanding of difficulties can be developed on the part of both nurses on the inside and out, each would benefit greatly. I suggest that the field nurse make appointments for her patients and not arrive unannounced with so many patients that she overcrowds the clinic, and that she should arrive a little early if possible. Then, when she arrives, if she would make her presence known to the nurse in charge of the clinic at once, her time at the clinic would be greatly shortened and tiresome waiting avoided. She can help speed up the history-taking by having facts ready for use.

By the same token, when the clinic nurse sees a strange field nurse, she should introduce herself and make the stranger feel at home. Appointments for future visits can be made and the policies of the clinic explained. The doctor's orders and findings should be given the field nurse in writing, if not at the time, by mail next day. These simple courtesies on the part of each nurse would do much to make the work easier, but more important still would do much for the comfort of the patient who is after all the real reason for the existence of the clinic.

The editors cannot refrain from pointing out a shortcoming on the part of many nurses and clinics. The field nurse should never use her costly time to transport children to clinic *if any other arrangement can be made through volunteer service,* and the nurse in charge of the clinic should never try to fulfill the duties of hostess and act as clinic nurse without the assistance of a volunteer hostess as well. The public health field nurse is apt to make the excuse that she must be at the clinic to hear what the doctor says about the patients. If the clinic is carrying on its job efficiently, the clinic nurse present at the examination should fill out a complete report for the field nurse and the nurse in charge should see that it is transmitted to the field nurse promptly by mail or telephone, which even at long distance rates is far cheaper than the day's salary of a nurse, oil, and gasoline.

The clinic hostess' duties have been described elsewhere (see PUBLIC HEALTH NURSING, January, 1933, and November, 1934). It takes time and patience to develop a good volunteer

service in the field or in clinic, but it is more than worth while in the aroused interest and wider understanding of your service on the part of the lay public. The National Committee on Volunteers in Social Work can give you information as to sources of supply for this service, and we suggest re-reading "The Volunteer—An Asset or a Liability," PUBLIC HEALTH NURSING, November, 1934.

Our readers will recognize some of the evils of overcrowded clinics in "Cured by Clinics" in the March, 1935, number of *The Readers' Digest*. What can we do about it?—*The Editors.*

State ERA Activities

This closes the state-by-state report on ERA activities that the magazine has been publishing since January. *The subject will be continued* under a new heading in August, "With the ERA Nurses," and will include information on state, county, and local FERA and ERA activities, experiences of the nurses, news notes, reports of work accomplished, new ideas, etc.—*The Editors.*

ARIZONA

In three counties in Arizona nurses have been employed on public health projects on FERA funds. In Apache County and Yavapai County the nurses have been carrying on maternity service and as much concurrent health education as time allows. The work in Maricopa County was organized in 1934 at Phoenix, under the Women's Work Division of the CWA. The original purpose of the project was to furnish work for unemployed nurses. Ninety nurses were enlisted in the original enrollment. Through this project, nurses were supplied to various organizations which needed such services, but were unable to pay for them. The remaining nurses were sent out to conduct a child health and sanitary survey in the families on relief.

Out of this survey grew a Visiting Nursing Service. The central office was in Phoenix and Nursing Supervisor was in charge there. From here, nurses were assigned to the outlying towns and communities in the county. Bedside nursing, surgical dressings, diabetic treatments, pre- and postnatal care, and the distribution of literature, were carried on under the direction of the county physician.

Much splendid work was done and real service was rendered to the families on relief. During this time twelve lectures on contagion, venereal diseases and pre- and postnatal hygiene, were given for the nurses by members of the Medical Society. Round table discussions of current problems were conducted at the headquarters office weekly. Very few of the nurses had had any special training in public health work, but all were graduate registered nurses and members of the State Nurses' Association.

On March 31st, 1934, due to a change in relief policies, the project was discontinued. However, in May, the demand for some form of nursing service for families on relief became so great that the project was again set up. Under the new organization, only nurses who were eligible for relief were employed. There was a full-time supervising nurse. About twenty nurses enlisted. Each nurse worked a given number of hours during the month at the prevailing rate for hourly duty.

In July, the FERA decided to conduct two-week health camps in the mountains for children from six to seventeen years of age who were underweight or undernourished and whose families were on relief. Before being sent to camp, each child was given a thorough physical inspection. This was done by members of the local Medical Society, who donated their time. Organization and management of these clinics were done by the nurses' office, which also furnished nurses for each camp where the children were sent.

From statistics compiled from camp records and the pre-camp examinations, it was found that an appalling number of these children were in very great need of dental and medical attention.

In October, a special Eye, Ear, Nose and Throat Clinic was conducted through the nurses' office. At the same time a full-time dentist, with a nurse assistant, was procured, and an office was equipped to do the necessary dental work.

Meanwhile the project had grown rapidly. It now includes a pediatric department to care for babies from ten days to eighteen months, conducted by a nurse especially trained in this work. It consists of home visits at regular intervals, instruction and assistance in proper preparation of formulas, a regular check of babies' weights and distribution of literature. A maternity department, with a nurse who gives prenatal instructions and cares for the mother and baby during the postpartum period. A department of contagion, with the nurse giving all bedside nursing in these cases, seeing that they are reported to the proper authorities and that proper quarantine is observed. She also teaches the proper methods of immunity and sees that children, who have not before received this treatment, are properly cared for.

In the main office is a registered pharmacist, who makes up simple prescriptions and dispenses stock drugs; a dispensary nurse, who gives first aid, does dressings and cares for the people who are able to come in for their nursing care. There is also a full-time laboratory technician, who does the necessary laboratory work for all persons who are employed in the work projects of the FERA. This includes Wassermanns, smears, throat cultures, and sputum tests on all food handlers.

A nurse from this office works with the county indigent officer helping to care for the nursing needs of these clients. Four nurses are also supplied for the county physician's office each month and the same number to the county welfare tuberculosis sanatorium. With the Phoenix office as a nucleus, clinics have been established in the outlying small towns and communities of the county. Nurses living in these communities are in charge and are responsible to the main office for the nursing care and health welfare of the families in their district.

At the present time, we have twelve nurses who have full-time positions and twenty who work part-time. The majority of these are active members of the State Nurses' Association; ten of the number are also members of the N.O.P.H.N. The *American Journal of Nursing*, PUBLIC HEALTH NURSING, and *Hygeia* are kept at the office and read by each nurse. Using Mary Gardner's "Public Health Nursing" as a text, we are conducting weekly classes, which all nurses are required to attend. These are supplemented by assigned reports and discussions of articles taken from the above-mentioned magazines. Attendance at all official association meetings is strongly urged, as well as enrollment, for any educational institutes given by either the medical or nursing groups.

To date, few of our nurses have had formal public health education, but they have done very creditable work, and are availing themselves of every opportunity for raising their educational standards.

It is impossible, at this time, to tell the extent of the benefit derived from this FERA nursing project, either to the nurses, or to the general public, but from the record of the past, we look forward with great hope to the future.

ROSE SHAUGHNESSY, R.N.,
Maricopa County FERA Supervising Nurse

COLORADO

Following two short-lived CWA nursing projects of late 1933 and early 1934, ERA nursing projects were begun in Colorado as county work projects in May, 1934. A nurse supervisor was appointed on the staff of the State Director of Relief to be responsible for the program and to supervise the work of the project nurses. Unemployed nurses were to be used within the counties in which they lived to give nursing care to ERA clients and to border-line cases.

In most counties the projects provided a full-time nurse on salary with varying number of part-time nurses working out budget needs. In a few counties several nurses on professional budgets were able to serve practically

full time. Some county projects included the use of practical nurses and housekeepers under the supervision of a full-time nurse.

The nursing program was planned on a broad basis, permitting a certain amount of school nursing and encouraging immunization for smallpox, diphtheria and in some areas typhoid. In undertaking any school work the nurses were asked to avoid wholesale inspection of pupils with the idea of uncovering defects for the correction of which no funds were available. Many imperative cases were reported, however, and every effort made to secure necessary corrections. Inspection of pupils for suspicious symptoms was encouraged in areas where infectious diseases prevailed. Nutritional work in schools was encouraged and the nurses have been particularly active in the distribution of cod liver oil and in efforts to increase milk and suitable food supply to undernourished children. Considerable attention has been given to an effort to secure school lunches in many schools.

Early in the program it was apparent that the nurses available for project nursing were, in most instances, inexperienced and unprepared for the type of work required of them, and that additional supervision and an educational plan were necessary. Through an adult education project, three public health nurses were secured to act as district supervisors. These nurses are sent into the field after the appointment of a project nurse to assist in outlining and organizing a program, starting adequate records, securing the approval of local physicians for the program and their sanction of standing orders.

The project nurses are grouped, where distances permit, for classes which meet with the supervisor for reading and discussion of public health nursing—its history and development, present-day trends, various programs possible, methods and procedure, and plans common to most of our county projects. Material for these classes has been obtained from several sources, principally from the N.O.P.H.N. Manual and from an outline formerly used by the New York State Board of Health and the University of New York in an educational program for county nurses. This outline has been adjusted to special needs, and other material has been secured from the United States Children's Bureau, the Metropolitan Life Insurance Company and from several state health departments.

Where nurses are remotely situated it is necessary to carry out the same educational plan for individuals.

ELIZABETH W. FORSTER, R.N.
State Supervisor for Nursing Projects

VERMONT

The present ERA State Nursing project is a continuation of the 1934 Civil Works Service under which a total of 60 nurses were given employment. That project was simple school nursing built around the Child Health Recovery program as recommended by the U. S. Children's Bureau. Our problem is different from many other states as we do not have county health units to which we can assign nurses. Each town is a law unto itself so it means very careful planning of territories for both supervisors and staff nurses. The staff nurses under CWS were assigned to the various school superintendents' districts. We were not able to start work until February 1st and between that time and the middle of April over 27,000 children were inspected. Because of the termination of CWS very little follow-up work was possible but in spite of this a considerable number of corrections were made. This work was carried on under the direction of the State Department of Public Health in coöperation with the State Board of Education.

In December, 1934, the State Health Department was again asked to assume direction of another project for unemployed nurses, the purposes were:

To provide employment for needy nurses.
To provide supplementary school and bedside nursing service and give emergency assistance to relief clients, the school work being in coöperation with the physical education program of the Board of Education.
To assist in laying foundations for an extended public health program for Vermont.

The project calls for a working personnel of 10 district supervisors, qualified nurses with public health experience, and 55 staff nurses of approved professional standing for school and bedside service.

Because of delay in securing necessary funds, and difficulty in obtaining supervisors the project did not start until January, 1935, and then in a very limited way. First we placed 6 nurses as assistants to already existing nursing associations in order that more service might be rendered needy patients and to allow the regular nurses extra time for school work. Four more were soon assigned to regular school nursing projects.

The project is based on the hope that this work will become permanent after Federal aid is withdrawn.

Previous to starting the general project the necessary record forms were printed and "Standing Orders for VERA Nurses" drawn up as well as a "Manual of Instructions."

Before the placing of the staff nurses the supervisor goes ahead, interviews doctors and dentists, obtains approval of the standing orders, explains the work to representative people in the town and forms a health or nursing committee. The overseer of the poor, health officer, and superintendent of schools are all included on the committee as well as other representative men and women. It is not possible under our project to furnish supplies for bedside care, so the committees are expected to see that the nurses have such equipment. School nursing supplies are furnished by the ERA. After this preliminary work the staff nurse is introduced to her field and the supervisor stays with her until she has an understanding of the work.

Very few of these nurses have any knowledge of public health work, but with painstaking and understanding supervision some splendid work is being accomplished. At the present time we have 5 supervising nurses and a total of 40 staff nurses. Many sections of the State are not as yet covered but we hope before the opening of schools in September to have our full quota in the field. We are meeting with wonderful coöperation from the doctors and dentists as well as the overseers of the poor as our nursing service means a lessening of the expense for care of the sick on their rolls. The health or nursing committees have regular meetings at which the nurse reads her report and plans are made for financing tonsil, dental, eye clinics, etc. In several towns money is being raised by community dances, and entertainments. In some towns enterprising supervisors have unearthed small sums of money remaining from a trust or other fund. (Vermont has never operated under FERA Rules No. 7.)

We are endeavoring to have the towns realize that these nurses are theirs and that they are largely responsible for the success of the service.

As to the nurses, not one of them thinks of her work as a stated number of hours per week, but rather it is a well loved work and obstacles only help to develop a greater desire to serve.

Each supervisor has a staff education conference every two weeks and here again our doctors and dentists are helping by giving informal lectures. The State institutions are being visited and every effort is made to give these nurses a better understanding of public health nursing and the nurse's place in a community.

In connection with our project for graduate nurses we are also using domestic nurses. The supervising nurse has charge of these women in her territory and we are using them to supplement our regular visiting nursing service in needy homes where continuous skilled care is not necessary.

Through the Visiting Housekeepers' Project directed by the Extension Service, we are contacting many prenatal cases as well as other types of cases suffering from illness and neglect.

The State Department of Public Health fully realizes its responsibilities as well as its privileges in directing this work, so intimately connected with the health and development of the people of Vermont.

NELLIE M. JONES, R.N.
State Advisory Nurse

WASHINGTON

The primary purpose of the first nursing projects was relief for unemployed nurses and caring for those ill in families on relief. To this end in 1934 19 public health-trained registered nurses were employed as supervisors under whose general direction approximately 300 graduate nurses served. covering all branches of nursing, including hospital, rural, school, and city. The projects were placed under the direction of the State Director of Health, the State Advisory Nurse acting in a supervisory capacity, making regular visits with particular attention to those new in field work, directing and assisting in immunization campaigns, and stimulating local interest in the work.

In June, the Washington Emergency Relief Administration approved a new state-wide nursing project for six months, beginning July 1 and continuing through December 31, under the direction of the State Department of Health.

The purpose of the present project is to give public health service in all communities in order that families on relief thus may be benefited. This project differs from former projects in several ways: public health training is a requisite for the forty-nine field nurses employed; nurses are chosen according to ability and experience and not from the standpoint of need; one supervising nurse is assigned to each of the six WERA districts instead of placing a supervising nurse in each county as heretofore. A special field nurse has been appointed to do the follow-up work on the survey of handicapped children which was made last spring under CWA. As in previous projects, the nurses are supervised by the State Advisory Nurse of the regular staff of the State Department of Health.

This project also made possible the appointment of a pediatrician to serve as Director of Maternal and Child Hygiene and to conduct itinerant child health conferences throughout the State. Since July 1, 49 conferences have been held in 17 counties, 2,081 children examined, 4,171 defects found.

Lack of funds for corrections is a serious handicap; nevertheless, much is being accomplished in assisting in the early detection of correctable defects in children, the prevention of the spread of communicable disease, including venereal and tuberculosis control, prenatal and postnatal instruction in the homes, instruction in infant, preschool, and school hygiene, urging the immunization of children and the correction of correctable defects, also instruction in home and community sanitation. The value of such a project to the community lies in the stimulation of interest in maternal and infant hygiene, the needs of the preschool child, a well-rounded, adequate health program in the public schools of the state and higher standards of preparation for healthful living in all communities.

The following tabulation is a brief summary of the weekly reports sent to this office by the nurses in the field covering the nursing projects under CWA, CWS, and WERA:

No. patients having bedside or nursing care	7,230
No. visits to tuberculosis patients	3,981
No. maternal case visits	8,285
No. pupils inspected in schools	335,360
No. defects found	62,180
No. corrections made	11,469
No. pupils excluded	4,393
No. conferences with parents	6,105
No. talks given	1,137

The state-wide nursing project closed March 31, 1935.

KATHARINE L. JENKS,
Secretary to State Advisory Public Health Nurse

Montana's Nurse-of-the-Month

LUELLA M. STICKNEY

I was born and educated in Minnesota, graduating from high school at Elbow Lake, and later taught school in Minnesota and North Dakota. Deciding to become a nurse, I entered St. Luke's Hospital at Fergus Falls, Minnesota, and completed a two years' course followed by a third year of study at the Kahler School of Nursing, Rochester. In September, 1923, I entered the University of Minnesota to take a course in public health nursing and after four months accepted a public health position in Faulk County, South Dakota. After six and one-half years at this post I returned to the University and completed my course. Seeking a change, I came to Dillon, Montana, as public health nurse of Beaverhead, one of Montana's largest counties, where I have served since September 1, 1930.

BEAVERHEAD, one of Montana's oldest and most historic counties, is situated in the extreme southwestern corner of the state. With an area of 6,000 square miles and more than half its population of 6,500 concentrated within a few miles radius of Dillon, the county seat, it is quite evident that the outlying districts are sparsely settled. Its cultivated lands are surrounded with far-flung forests which mantle rugged and picturesque mountains making this county admirably suited for its main industry—stock raising.

Thus, in an area almost twice that of the states of Delaware and Rhode Island combined, the county nurse looks after the health of the widely scattered rural population living on the large and small ranches in the various villages. Lacking organized agencies for the work, she also acts as investigator and advisor for the public relief work carried on by the board of County Commissioners. It is necessary to travel thousands of miles for a single complete tour of the county and all but the north and south trip is done on roads and highways varying from good to barely passable, depending upon the season and the locality. Indeed, Centennial Valley and the Big Hole Basin are snowbound except for special powered sledge outfits for weeks at a time in the winter.

Public health nurse service was started here in 1924 through the efforts of the County Federation of Women's Clubs. Funds from the American Red Cross and the sale of Christmas Seals were used with a county appropriation to pay salary and expenses.

There are 31 rural schools scattered in the outlying districts and it is around these that the work centers. All infant, preschool, prenatal and other visits are made about the surrounding communities when the schools are visited. At the spring visit, the teachers are notified in advance and the parents are invited to attend with the smaller children so that a preschool and infant conference is conducted at this time.

The County Nursing Committee is

chosen by the County Federation of Women's Clubs with the approval of the Commissioners. These women represent the Red Cross Chapter, P.T.A., Shakespeare Club, and rural organizations. The group meets semi-annually with the Federation which is formally reported to by the nurse. Also each year a mimeographed report for the twelve months is sent to all interested groups.

A typical visit showing the routine as well as the special service in a community was made early last April in company with the Red Cross field representative who visited at the time. The trip was made to the Big Hole Basin—first stop 50 miles away. Concentrated work in the small towns had been planned, comprising preschool conferences, school surveys, talks to parents and home calls. The meetings were uniformly well attended. Every small child from a nine-weeks-old baby to those about to enter school were brought by mothers and many were also accompanied by grandmothers.

Meals and lodgings are never a problem on such trips. Hospitable invitations awaited us at each stop and the field representative had a graphic picture of a wonderfully scenic country and was also impressed with the keen interest shown in this work by everyone. At rural school visits, both mothers and fathers attended.

While at one "home-visit" two children came and asked me to come to their home on a sick call. Also the principal of the school arrived to recite the trouble she was having in the control of a measles epidemic. The proper legal and health procedures were outlined and calls planned on all the ill. More calls came by telephone so that before leaving this first house-call, a round of visits was planned to include all. This lasted until late into the night.

Next day school inspection was started—a check-up on the very thorough one made during the fall. A mother called to request a visit to her daughter who was an expectant mother. The young woman was advised to see her doctor at once and gladly accepted an offer to be sent letters on prenatal care issued by the State Board of Health. The literature was particularly welcome as this was her first pregnancy.

The measles cases were found to be quite ill—some of the children with temperatures of 104 degrees. As this community is isolated and 70 miles from a doctor—one is not called until the need is imperative. Often the nurse is called upon to take responsibilities unheard of in more populous communities and it is sometimes difficult to impress people with the necessity of keeping one's status as a public health nurse and not trespassing upon the doctor's functions.

On this trip with spring at hand, there was interest in the serum for inoculation against Rocky Mountain Spotted Fever—locally known as "tick fever." While many cases do not occur here, there are usually a few infections each spring and inevitably, over a period of time, fatal cases. For this reason clinics are arranged for each spring in these communities with doctors to administer the serum at a very nominal charge to cover transportation expense, as the serum is furnished free.

With such a scattered population over such a great area, the range of activities undertaken is necessarily limited, but with the excellent coöperation given in all the communities here, it makes one feel that everything possible should be done to protect and improve the health of all the residents.

Here and There in the Field

THE staff nurses of the Springfield, Mass., Public Health Nursing Association conducted a very challenging panel discussion on the subject of supervision at a recent staff meeting. The "what, why, how, and when" of supervision received animated attention—the panel being composed of an assistant supervisor, staff, student, and ERA nurses. The audience joined in the discussion at the close of the meeting. This method of approach by staff nurses to phases of our work that are of mutual interest to all seems very desirable. Other subjects that would lend themselves well to this type analysis are generalized versus specialized services in public health nursing, methods of health teaching, relief-giving, community relationships, this question of mental hygiene, etc.

Panel on Supervision

WENT to Pirate's Cove Camp in Miami; while there Sam Willie told me that his wife was sick. I went over to their platform and discovered that she had a badly abscessed breast. I told Sam Willie that the doctor should see it, and that if he wanted me to I would call the doctor. Sam said, "All right, you call 'em." Doctor Holmes went out to the camp, decided that the abscess was not ready to be opened, but ordered a poultice that night and twice the next day and then I was to call him on Friday morning and he would go to the camp and open the abscess.

I went off, got the material for the poultice, returned to camp and applied it. The next morning I went again. This time the patient was a bit reluctant but finally consented; but that evening when I went the patient was nowhere to be found. Frank Willie, a relative and head of the camp, came to me and said: "She has Indian doctor, she all right now." I asked him if the abscess had opened, and he said: "Yes, get well." I was skeptical, so said: "Very well, if it is open it will get well, but I would like to see it." He sent a little Indian girl to fetch the patient but she failed to appear. He then said to me: "You tell the doctor no come cut 'em, she all right now." I told him that I would tell the doctor, but that I would be back the next day to see how she was feeling. On the way home I met her husband. He too assured me that his wife was better. I also told him that I would be back the next day to see her. He said, "You come tomorrow," and I rode off thinking how futile it all was and tried to forget it.

"Doctor Cut 'em Big?"

Next morning I called Dr. Holmes and explained it to him and he said there was nothing we could do about it, we would just have to let it go.

After luncheon I went back to their camp and found Sam and his wife on their platform. I said very casually, "All right now?" Silence—and just as I thought, it was not better, but it was ready to be opened. I told Sam that had he let the doctor come and open it that his wife would be feeling better now. Nothing was said for sometime, then a long conversation in Indian between Sam and his wife, Sam evidently translating what I had said. Then Sam said to me: "Doctor cut' em big?" I explained that it would only be a small incision. Again another long conversation in Indian between Sam and his wife. Then to me: "Hurt 'em much?" I told him I was quite sure that the doctor would put something on it so that it would not hurt. Then followed another long conversation in Indian and—silence. I waited sometime and then explained, as simply as possible, just why it would be best to let doctor open it. After I had exhausted all my arguments for it, I again waited. There was another long conversation in Indian and another long silence, through which I sat patiently wondering the outcome.

While I sat through this long silence, I thought of a time some years ago, in

India, how I had bargained off and on all day for a string of jade beads. The locale was different, the wares certainly different—but somehow the psychology of it seemed the same. The method was certainly Eastern—unemotional, calm, slow, with time meaning nothing. Perhaps it was this long bargaining some years back that was responsible for my not packing up my wares and going off.

Finally, after what seemed an eternity, Sam Willie looked up and said, "All right, you bring the doctor." I knew then that it was settled. It was then late afternoon. I called Dr. Holmes and we went to camp and he opened the abscess.

Sam watched the operation with a great deal of interest, evidently to see that it was carried out as I had explained it to him. In a couple of days the patient was much improved. A week later I was back in that same camp, and Sam told me that his wife had another abscess, that the doctor had seen it, and he added, "Don't know when the doctor going to cut 'em." No question this time about whether to have it done or not, the other had healed quickly—that was proof enough.

From it all I discovered that one could bargain with Indians for things other than jade beads and carved ivories. One could barter health and relief from pain, for confidence and good will—if one but took the time.

CHARLOTTE CONRAD
Office of Indian Affairs, Department of the Interior, Washington, D. C.

DOES a staff nurse need to continuously refresh her memory? Does she need to learn more about the teaching content of a nursing visit? Does she need to brush up on her technique? Does she need to familiarize herself with old and new allied agencies?

For some time our staff supervisors and field nurses were aware of the fact there was something going on in our Teaching Center that they needed to know more about. So in 1927 we established what we like to call our "Refresher District."

A Refresher District

We had established a Teaching Center in 1922 for student nurses of various hospitals who come to us in their senior year for two months' experience in public health nursing and here we maintained a teaching staff whose duty it was to keep abreast of progress in nursing and to try out all new methods in technique. Each of the five districts in this center were teaching districts and each of the five staff nurses were teaching nurses. We added a new district to this center. The district chosen was one in which travel was average, a cosmopolitan people, many owning their own homes but a greater portion being transient.

The regular staff nurse who had been on the staff the longest was chosen first and so on until every regular staff nurse had gone to the "refresher district." It takes about two and one-half years for our entire staff of nurses to reach the district and then we start over again. The nurse stays one month. We use the same district for introducing new nurses to our staff. The Assistant Teaching Supervisor has charge of this district. The nurse has assigned readings, writes one book review, keeps a monthly record of activities and the time spent in each, visits certain social agencies, visits and assists in various clinics. She observes the supervisor demonstrate each phase of public health nursing activities and returns the demonstration. She observes the administration and teaching of student nurses.

Nurses as a whole like the refresher system; many a nurse has gone back to her regular district with new ideas and in a happier frame of mind. One nurse said, "It's like going away to school." Often the supervisor gets new ideas, too, from nurses who are always alert and have much to offer from years of experience in the work.

Do the patients resent new nurses in this district and does a district run down because of the frequent changing of nurses. We do not find it so. In the seven years the number of patients cared for in this district has doubled, until we are

considering making the district smaller. The supervisor sees these patients frequently and they consider these nurses her assistants. It has been our experience in this district, as in the districts where we teach senior student nurses, the more nurses seen, the more work we have to do.

Our organization has a generalized nursing program embracing maternity and newborn care, morbidity, including tuberculosis, and health supervision. It also maintains a free dispensary for women and children, and a number of weighing stations for well babies and preschool children.

We feel we have benefited greatly by this system of staff education.

S. GERTRUDE BUSH, R.N.
Assistant Superintendent, Toledo District Nurse Association

Feet First

AMERICA, for years having traveled head first while sleeping in passenger vehicles, will have to about-face to enjoy maximum safety and comfort a-wheel.

The prime reason for arranging sleeping compartments in passenger vehicles with the head in the direction of travel was to protect the passengers from direct drafts and dirt from open windows, but this reason is being eliminated by the advent of air conditioning.

By changing the sleeping position in vehicles to feet first, which corresponds to sitting face forward, "car sickness," due to lying head first, which corresponds to sitting backwards, will be eliminated. Congestion of blood in the head will be minimized, for sudden stopping and starting of vehicles tends toward blood congestion in the extremities, and since the stopping of vehicles is more sudden and violent than starting, by lying feet first these rushes of blood are toward the feet and the effect comparatively innocuous. However, the most important factor is that of safety, and it is figured that many travelers have lost their lives in nocturnal accidents by being rendered insensible and unable to help themselves when thrown violently head forward against the front of their sleeping compartments. This would be overcome by sleeping feet forward.

—From a study by the Scully-Walton Ambulance Service, January, 1935

A Staff Scholarship Fund

IN Pittsburgh, Pa., a fund for scholarships has been created through the honoraria paid by various schools of nursing for lectures given by executives of the Tuberculosis League and the Public Health Nursing Association, and the boards of the Tuberculosis League and the Public Health Nursing Association have permitted this money to be assigned as a scholarship fund for the nursing staff of the Public Health Nursing Association. The scholarships are awarded by a committee consisting of the executives of both agencies.

One scholarship of $400 for eleven months' study is given as a direct grant to any staff nurse who meets the following conditions:

1. Work in the Association for not less than twelve months preceding.
2. Ability to comply with the academic standards of the institution in which her course is taken.
3. Preparation of a special report or thesis based on her year's work.
4. Agreement to return to the Association for at least one year (twelve months) of work immediately after the close of her scholarship year.

$200 optional as a loan without interest, to be repaid within three years after the nurse returns to work.

The holder of this scholarship will be required to take at least one course leading towards the preparation of a report or thesis. This report shall be something helpful to the work of the Association and must be presented at the close of the year. The subject will be selected either before the student begins her course or very early in the course. It will be the understanding of the

student, the committee and the instructors that the student is to be given every assistance in making this report or thesis of value to our Association and to public health nursing generally.

This scholarship will be competitive. Its award will be based upon the work of the candidate during the preceding year, and upon a brief written report or theme on a given subject, which each candidate will be asked to submit.

The remainder of the income from this fund will be spent in two or more scholarships awarded for short courses or for observation visits for the purpose of studying methods and conditions, and may be given to any member of the nursing staff. Any worker receiving such a scholarship must have been with the Association for not less than twelve months; must agree to return to the Association for at least one year; and if the scholarship is awarded for any special course, the candidate must meet the requirements of the institution in which the course is offered.

Each worker accepting such a scholarship, either academic or traveling, will be asked to present a written report of her study at the termination of her leave of absence.

The length of the leave of absence and the amount of money appropriated will depend upon the time required by the course to be taken or the work to be studied.

Ten staff nurses have benefited by the scholarship fund and for purposes ranging from the eleven months' graduate study at a university, to an observation trip to other associations. For the next school year (1935-36) three more nurses have been granted scholarships and loans for the purpose of taking postgraduate courses in public health nursing.

The scholarship fund has also been used to finance institutes (one mental hygiene, one social hygiene, and one prenatal) and special lectures (five) for the entire staff and plans are now afoot to finance a mental hygiene institute next autumn on a fifty-fifty basis with the Staff Council. We also use small amounts from the scholarship fund when we are offering prizes for competitive efforts on the part of staff and student nurses, as, last autumn, a poster contest was held in connection with our breast feeding campaign. At the present time a case study contest is on (first prize, $10; second prize, $5).

HELEN V. STEVENS
Director, Public Health Nursing Association, Pittsburgh, Pa.

AN EFFECTIVE PUBLICITY EXHIBIT

The nurse assists the doctor at time of delivery

The nurse gives, and teaches the family to give, adequate home care of communicable diseases

An appointment call brings the nurse at a time most convenient to the patient

Baby Station—keeping well babies well

The nurse-teacher in the classroom

Administration—so that the nursing service may function smoothly

THIS model showing phases of a generalized nursing service was made for store window and general exhibit purposes. It was built by a local carpenter out of hard wood, except the back and room partitions, which are of beaver board. All members of the staff and many board members participated in making the house under the direction of Miss Helen Lovell, office secretary, who planned the project. The only cost to the Visiting Nurse Association was for building the frame and walls of the model; everything else was donated.

The six rooms were fitted into a frame 42 inches long, 30 inches wide, and 21 inches deep. The dimensions of the glass opening are 36 x 24 inches, and the rooms are approximately 12 inches in each dimension. This leaves a 6-inch space behind each room and a 3-inch space beside the end rooms. These spaces are used to give the impression of adjoining rooms or views through the windows (see adjoining office, consulting room, nurse's Ford outside of school room, etc.).

The whole house is lighted by a Christmas tree circuit, a light in each room and in the spaces in the back and side. In each room the walls are papered, trim painted, and floors covered with paper simulating carpet and linoleum.

The furniture is mostly of five-and-ten-cent store variety with the exception of the school room and office furniture, which was drawn to scale and made of brown cardboard.

The patients in bed are five-and-ten-cent store dolls. The upright figures are cut from magazines—fashion sections, advertisements, etc. Gray uniform material was pasted over the figures of the nurses, the shading, ties, etc., painted on. The aprons are made of paper. All the furniture and upright figures are glued to the floor.

MARGARET C. McCUTCHEN,
Plainfield Visiting Nurse Association, New Jersey

? ? ? Question Box ? ? ?

INDUSTRIAL NURSING

These questions have been sent to the magazine by various industrial nursing groups in the country. In some cases the club has answered its own questions for publication; in others, the N.O.P.H.N. staff has given an opinion; in still others, the answer of an expert has been secured.

QUESTION:

Should an industrial nurse be interested in preventive measures in health in the course of her work?

ANSWER:

Absolutely. First of all she should be a health teacher, pointing out the facts that are detrimental to health, suggesting safeguards to prevent illness and accidents, which are more valuable than remedies, and she should put health literature at the disposal of employees.

QUESTION:

Do health and accident records play an important part in the daily routine?

ANSWER:

They are very important. Particularly is this true in cases of the tiniest scratch or puncture wound. Reports on this type of wound should be accurately recorded; how it occurred, where, also the condition when first seen in the first aid department. The type of wound is very important because the infinitesimal injury often turns out to be the most costly, even ending fatally. The big things take care of themselves; it's the little things that need watching.

QUESTION:

How much medical care can be expected of the industrial nurse by the company employing her?

ANSWER:

Medical care should be given only as a first-aid measure. The well-trained graduate nurse who understands her work knows better than to take on more responsibility because she realizes she must not assume the responsibility that rightfully belongs to the doctor. She should be aware of the fact that to go beyond first-aid measures is unfair to herself, to the employee, to the employer, to the doctor, and that she is not prepared educationally to carry such responsibility.

Industrial nurses know that often the partly-trained nurse or first aid worker with no knowledge of medical ethics or technique, except a few lessons in first aid (more often none at all) loves to flaunt her knowledge on the laity and because they dress in white and are called "nurse" or "doc" the employees think they are trained people. Many of the employers never inquire as to the status of these persons, who are usually selected by the employment manager, whose knowledge of nurses is very meager, consequently because of these types the industrial nurse often comes under the general criticism of practicing medicine. The nurse may safeguard her position by securing standing orders from the doctor for common ailments.

QUESTION:

How can the industrial nurse secure medical care for employees beyond that furnished by the company doctor?

ANSWER:

By detecting early symptoms of mental or physical diseases and encouraging the individual to consult his physician if he has one. If not, she can contact the local Medical Association, getting names of members, then submitting them to the employee and letting the patient do his own choosing, knowing he cannot go wrong with this background. She can also help the diagnosis by calling the doctor and explaining home and financial conditions, also what his health habits are. Every bit of history she can gather will aid the doctor materially.

QUESTION:

Has the industrial nurse any unusual opportunities at the present time to teach health?

ANSWER:

Yes, because there is rampant right now more cure-alls and symptoms sent through the medium of the radio, magazines and newspapers than ever before. One must diagnose his own case, then rush to the stores for the remedy. Whenever a person comes to the First Aid Department to inquire as to the merits of the nostrum, the nurse can help materially. First of all she should be a good, sympathetic listener, then proceed to sell him good advice. After inquiring regarding his symptoms and conditions and discovering sometimes what the person needs is no remedy at all other than right living, getting the

proper amount of good nourishing food, plenty of sleep or change of environment (and in other cases what the employee needs is good medical care which cannot be purchased over the radio) she can explain the fact that medicines, unless prescribed by an authority after a consultation, might prove very harmful. Furthermore, a medicine that cures everybody and every symptom is good for nothing; also, if a doctor with all his knowledge in science and up-to-date methods can make mistakes in diagnoses, Heaven help the person when in the hands of the advertising experts of nostrums.

QUESTION:

Should the industrial nurse belong to other organizations besides her professional groups?

ANSWER:

Besides her state and district nursing associations and the public health nursing section of either of these, it is an excellent plan, if possible, to be a member of the local Tuberculosis Society, Social Workers' Club, Mental Hygiene Society, and Business and Professional Club. These associations tend to broaden her vision. The more contacts she makes, social, professional, or religious, the richer she is to carry on. It would be well to develop a hobby if she has not one already. To remain in the First Aid group alone means stagnation of her mental and physical powers.

QUESTION:

The standing orders from my plant doctor do not allow me to give aspirin when employees come in and ask for it. Our doctor thinks any condition calling for aspirin calls for a doctor's attention first. The employees pass around their own aspirin and complain about a first-aid room that does not supply aspirin. What should I do?

ANSWER:

Is there any chance for talks to employees in your plant? It would be well to have the doctor explain to all the workers simply and clearly why aspirin is not approved and why certain conditions call for a doctor's examination rather than a tablet. Such a talk might be followed by some reminders in the form of posters placed on bulletin boards or at other conspicuous points—"Headache? Don't dose yourself. See the doctor." "Coming down with a cold? Report at once to the doctor." "Having pain? Don't mask it with a drug—See the doctor."

If there is no chance for talks, the nurse should take time to explain to each worker when he asks for aspirin why aspirin is not a cure and may delay much needed care. There should be posters in the waiting room and the doctor should prepare a simple statement about the danger of neglecting conditions or masking them by drugs.

QUESTION:

Recently one of our unmarried workers became pregnant. She did not report herself, but was reported by a fellow worker. I sent for her and asked her as tactfully as I could what she planned to do about it. She was surprised that her condition had been noticed —I let her suppose I had noticed it—as the baby was not due for two months. She refused to talk, refused to return to her department, and said she was going to "run away where no one can find me." I asked her to wait in the rest room and to let me walk home with her after work so we could talk it over, but she said, no, she wasn't even going home. She left the building. I telephoned the police, explained and gave them her home address and reported to our personnel manager. They never located her and we have never heard from her. Was there anything else I could have done?

ANSWER:

It seems as though you did all you could after the girl insisted on leaving the plant. However, did you ever visit the department where this girl worked? Have you any chances to see all the workers regularly? Had the foreman or forewoman noticed her condition? Do all the women workers understand what rules you have for maternity leave? It looks as if this girl was driven to running away for fear of facing her coworkers. It might have been well to talk to the girl's forewoman before talking to her and to have started your talk with the girl by showing interest in the coming baby and asking if she was planning to return to work after the baby came, rather than asking her what she "planned to do about it." Are you sure your voice did not carry a note of disapproval and so turn her against you? This is the most delicate situation a nurse ever has to handle. Have you asked the advice of any social workers in your community as to how they would have handled the matter? Have you talked with the personnel manager? Some reference reading in *The Family* on the problem of the unmarried mother follows: (This periodical should be obtainable at the local family welfare department or agency or may be ordered from the Family Welfare Association of America, 105 East 22nd Street, New York, N. Y.)

November, 1928, p. 240, The Unmarried Mother (Smill).

April, May, June, 1925, Milestones in the Approach to Illegitimacy (Drury).

April, 1929, p. 54, (Interview).

May, 1929, p. 74, An Interview.

May, 1929, p. 80, (Rural Community).

October, 1932, p. 185, Case Work with Unmarried Mothers (Mathews).

January, 1933, p. 316, Paternity? (Penrose).

May, 1933, p. 75, Objectives in Work with Unmarried Mothers (Henry).

January, 1934, p. 310, Changing Emphases in Case Work with Unmarried Mothers (M. F. Smith).

November, 1934, p. 229, Humble and Distracted (Brisley).

See also "The Illegitimate Family in New York City." Ruth Reed. New York, Columbia University Press. $3.75.

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

HONOR ROLL

The following is a list of agencies holding 100 per cent nurse membership in the N.O.P.H.N. enrolled during May. For those already enrolled for 1935 see the previous numbers of this magazine beginning with March. Asterisks indicate the number of years an agency has held 100 per cent membership.

ARKANSAS

**Metropolitan Life Insurance Nursing Service, Little Rock

CALIFORNIA

*Metropolitan Life Insurance Nursing Service, Fresno
*Metropolitan Life Insurance Nursing Service, San Diego
*Metropolitan Life Insurance Nursing Service, San Jose
***Visiting Nurse Association, Santa Barbara

COLORADO

***Weld County Red Cross Public Health Nursing Service, Greeley

CONNECTICUT

**Visiting Nurse Association, Branford
*District Nurse Association of Ansonia, Derby, and Shelton, Derby
**Public Health Nursing Association, East Hartford
*Visiting Nurse Association, Fairfield
**American Red Cross, Naugatuck
***Visiting Nurse Association, Newtown
***Public Health Nursing Department of the United Workers of Norwich
*Red Cross Nursing Service, Stratford
*Public Health Nursing Association, Waterford
*Visiting Nurse Association of the Town of Windham, Willimantic

DISTRICT OF COLUMBIA

**Child Welfare Society, Washington

FLORIDA

*Junior League, St. Petersburg
*American Red Cross, West Palm Beach

ILLINOIS

**Metropolitan Life Insurance Nursing Service, Alton
*Health Center, Elgin
**Ogle County Tuberculosis Sanatorium Board, Oregon
**Cheerful Home Association, Quincy

INDIANA

*Noble County Public Health Nursing Service, Albion
*Community Nursing Service, Alexandria
*Lake County Health Commissioners, Crown Point
*Child Welfare Association, Elkhart
*John Hancock Mutual Life Insurance Nursing Service, Gary
*Elkhart County Public Health Nursing Service, Goshen
*American Red Cross, Goshen
*Metropolitan Life Insurance Nursing Service, Hammond
***City Schools, Huntington
*Shortridge High School Nursing Service, Indianapolis
**State Board of Health, Indianapolis
*School Nursing Service, Lafayette
*LaGrange County Public Health Nursing Service, LaGrange
*School Nursing Service, Logansport
*Metropolitan Life Insurance Nursing Service, Michigan City
*Ball State Teachers' College Nursing Service, Muncie
**Delaware County Tuberculosis Association, Muncie
*Floyd County Tuberculosis Association, New Albany
*Public Health Nursing Service, Newcastle
*Vermillion County Public Health Nursing Service, Newport
*School Nursing Service, Valparaiso
*Metropolitan Life Insurance Nursing Service, Vincennes
*School Nursing Service, Whiting

IOWA

***Visiting Nurse Association, Council Bluffs
*Iowa Tuberculosis Association, Des Moines
**Visiting Nurse Association, Marshalltown

KANSAS

*Public Health Nursing Association, Arkansas City
***McPherson County Public Health Nursing Service, McPherson
*Public Health Nursing Association, Wichita

KENTUCKY

****Public Health Nursing Association, Lexington
*McCracken County Public Health League, Paducah

LOUISIANA

*Allen Parish Red Cross Chapter, Oakdale

MAINE

****District Nursing Association, Portland
***American Red Cross, Saco

MASSACHUSETTS

*John Hancock Mutual Life Insurance Nursing Service, Everett
***American Red Cross, Melrose
***Instructive District Nursing Association, Milford

MICHIGAN

***North End Clinic, Detroit
*Tuberculosis Society, Saginaw

MINNESOTA

*Metropolitan Life Insurance Nursing Service, Duluth
*John Hancock Mutual Life Insurance Nursing Service, St. Paul

MISSISSIPPI

**Union County Health Department, New Albany

NEW HAMPSHIRE

***District Nursing Association, Concord

NEW JERSEY

*Visiting Nurse Association of Somerset Hills, Bernardsville
*American Red Cross, Bridgeton

**Camden County Tuberculosis Association, Camden
*Visiting Nurse Service of Hackensack and Vicinity
**Public Health Nursing Association, Long Branch
****Public Health Association, Matawan
***Visiting Nurse Association, Merchantville
***Anti-Tuberculosis League, Orange
*American Red Cross, Pleasantville
**Red Cross Public Health Nursing Service, Rahway
*Somerset County Health Association, Somerville
*Pascack Valley Nursing Service, Westwood

NEW YORK

*Metropolitan Life Insurance Nursing Service, Auburn
*Metropolitan Life Insurance Nursing Service, Binghamton
****Visiting Nursing Association, Buffalo
*District Nursing Association, Carmel
***Visiting Nurse Association, Mt. Vernon
*Judson Health Center, New York City

NORTH CAROLINA

*Metropolitan Life Insurance Nursing Service, Gastonia

OHIO

****Western Reserve University Public Health Nursing District, Cleveland
*Metropolitan Life Insurance Nursing Service, East Liverpool
***Red Cross Public Health Nursing Service, East Liverpool
***Public Health League Nursing Association, Hamilton

OREGON

**Clackamas County Health Unit, Oregon City

PENNSYLVANIA

*Family Welfare Organization, Allentown
*Metropolitan Life Insurance Nursing Service, Allentown
*Visiting Nurse Association, Bethlehem
*District Nurse Committee of the Civic Club, Carlisle
***Delaware County Tuberculosis Association, Chester
**Visiting Nurse Association, Fleetwood
*American Red Cross, Honesdale
***Visiting Nurse Association of Eastern Delaware County, Lansdowne
*Metropolitan Life Insurance Nursing Service, McKeesport
*Nursing Service, Milton
*American Red Cross, Mt. Pleasant
*Montgomery County Tuberculosis and Public Health Society, Norristown

SOUTH CAROLINA

*Metropolitan Life Insurance Nursing Service, Greenville

TENNESSEE

*Metropolitan Life Insurance Nursing Service, Bristol
*Anderson-Campbell Health District, Clinton
*Pi Beta Phi Settlement School, Gatlinburg
*Greene County Department of Health, Greenville
*East Tennessee State Teachers College, Johnson City
**Roane County Health Department, Kingston
*City Health Department, Memphis
*State Department of Health, Nashville
***Sevier County Health Department, Sevierville

VIRGINIA

*Instructive Visiting Nurse Association, Hopewell
***Instructive Visiting Nurse Association, Newport News
****Instructive Visiting Nurse Association, Richmond

WASHINGTON

*Metropolitan Life Insurance Nursing Service, Spokane

WEST VIRGINIA

***Public Health Nursing Association, Charleston

WISCONSIN

***Attic Angel Association, Madison
**Wisconsin Anti-Tuberculosis Association, Milwaukee
**American Red Cross Public Health Nursing Association, Racine

J. V. S. APPOINTMENTS

Joint Vocational Service reports that there has been a slight increase in the number of open positions reported in the first five months of this year in comparison with a similar period last year. Last year was an improvement over 1933. The increase is not sufficiently significant to enable them to say there is a definite upward trend in the employment of public health nurses.

Nurses whose appointments have been effected by Joint Vocational Service or assisted by them, are as follows:

Mrs. Ruth Ensle Connor, as county tuberculosis nurse, Montgomery County Health Association, Crawfordsville, Indiana.

Jean McAllister, as head nurse for Nursery, St. Barnabas' House, New York City.

Ruby Irene Gronner, as generalized supervisor, Visiting Nurse Association, Bernardsville, N. J.

Emma Haines, as county nurse, American Red Cross Chapter, Stroudsburg, Pennsylvania.

Helen Kienzle, as supervisor, American Red Cross, Pawtucket, Rhode Island.

Helen Heffner, as school nurse, Public Schools, Suffern, New York.

Else Norden, as head nurse, Infants' Home of Brooklyn, Brooklyn, N. Y.

Mrs. Rama P. Prenner, as county supervising nurse, Vermont Emergency Relief Administration, Rutland, Vermont.

Ann M. Keating, as community nurse, Health Department, Tuxedo, New York.

Elizabeth M. Hill, as nursing field representative for Pennsylvania under the American Red Cross, Washington, D. C.

Josephine Daniel, as nursing consultant, Division of County Health Work, North Carolina State Board of Health, Raleigh, N. C.

Mrs. Helen Foley Leighty, as secretary of Information Bureau and Clearing House under the Children's Welfare Federation, New York City.

Mrs. Jessie F. Sampson, as colored staff nurse, Children's Aid Society, New York City.

Anne Marie Hellner, as temporary superintendent, Visiting Nurse Association, Bridgeport, Conn.

EDITED BY
DOROTHY J. CARTER

INFANTILE PARALYSIS

By George Draper, M.D. Appleton-Century, New York, 1935. $2.00.

All nurses should become familiar with the book, "Infantile Paralysis," written by Dr. George Draper. The subject is presented in such an interesting manner that one's desire is to read on without interruption until it is finished. It does more than create a feeling of interest, however. As each chapter unfolds, one becomes aware of a growing sense of relief. When analyzed, this feeling seems to come from the fact that here is a book not too technical, yet thoroughly convincing, which deals with a baffling disease (to the lay mind at least) in a concrete rather than abstract form.

The theory of susceptibility is thought-provoking. The chapter on the portal of entry sounds plausible. The influence of the human factor as well as the nature of the virus are both explained simply and effectively. And the discussion on the value of the serum should remove any feeling of doubt as to what procedure to follow should the occasion arise.

The horror of the actual disease is not minimized. Nowhere in the book is one allowed to feel that vigilance in regard to preventive measures should be abandoned. The description of the symptoms of the case during the acute onset are sufficient to make anyone realize that no precaution is too great to offset or wipe out the disease.

The book should be of particular value to public health nurses. It gives them an excellent foundation in the knowledge of the disease, which is essential in their work. Having obtained this information, they must not think that their responsibility ceases. An understanding of the problems which occur during the period of convalescence, with the added knowledge of the type of treatment which should be given, will enable them to perform a service which will be far-reaching in its effect. There is no better way that they can serve the medical profession and the community.

ELMA HARRISON, R.N.

Two new novels about doctors and their devotion to the ideals of medical service have recently been published—"Dr. Mallory" by Alan Hart, published by W. W. Norton & Company, New York, $2.50; and "Barry Scott, M.D.," by Rhoda Truax, published by E. P. Dutton & Company, New York, $2.50. Both books are enriched by their treatment of problems which confront doctors and the public.

A committee of home economists in social work and the social service department of the American Home Economics Association has been formed to prepare a statement of information regarding budgeting, food allowances, and nutrition with which both the social worker and home economist in a social agency should be familiar. The committee has prepared an outline of suggestive material to be covered in a course in social case work, which could be adapted to meet the needs of individual groups. The "Suggestive Outline of Budgeting and Nutrition to be Included in Short Courses in Social Work" appeared in the May, 1935, issue of the *Journal of Home Economics*, Baltimore, Maryland.

Three Family Narratives: For Use in Parent Education Groups, with a discussion of the problems of study-group leadership. By George K. Pratt, M.D., National Council of Parent Education, 60 East 42nd Street, New York. A new

and interesting analysis of the study-group situation with emphasis on the emotional element that exists between leader and group. 75 cents.

FOR INDUSTRIAL NURSES

"State Reporting of Occupational Disease, Including a Survey of Legislation Applying to Women." 99 pages, charts. Women's Bureau Bulletin No. 114. 10 cents. An analysis of the occurrence of occupational disease from reports made to state authorities.

An illuminating and interesting article, "Occupational Hazards in the Agricultural Industries," written by Robert T. Legge, appeared in the *American Journal of Public Health*, April, 1935. The article deals with the hazards connected with plowing, harvesting, truck gardening, nursery work, fruit handling, cattle and dairy work, etc.

FROM THE SOCIAL WORK FIELD

The third issue of the "Social Work Year Book 1935" has recently been published by the Russell Sage Foundation, giving a description of organized activities in social work and in related fields. The articles have been revised to show changes in social work since the beginning of the Roosevelt Administration; the directory of Social Agencies in Part II now includes Federal emergency agencies as are closely related to social programs. $4.00, Russell Sage Foundation, 130 East 22nd Street, New York.

Six 1935 pamphlets are available from the Family Welfare Association of America, 130 East 22nd Street, New York:

The Layman Looks at Family Social Work, Mrs. John D. Rockefeller, 3d; Do Professional Standards Help Families? Dorothy C. Kahn; Family Life and Recovery, Dr. Harry Emerson Fosdick. 20 cents.

Relation of Public and Private Family Agencies, Mary L. Gibbons. 15 cents.

Effect of Economic Unemployment on Family Life (Report of a Philadelphia Committee). 35 cents.

Family Consultation Service as a Function of a Family Agency, Dr. Julian E. Benjamin. 10 cents.

(May be ordered singly—or the four pamphlets sell for 60 cents.)

Family Consultation and Family Case Work (Report of a Cleveland Committee). 25 cents.

Central Application Bureaus, Virginia Maxwell. 15 cents.

For the convenience of social workers in New York City the Family Welfare Association of America has opened a bookshop and lending library called The Social Work Bookshelf, on the street floor of the Russell Sage Foundation Building, 130 East 22nd Street, New York City. The more popular social work books will be available and orders will be taken for any book. A deposit of $1.50 will be required and books may be borrowed for 5 cents a day.

FROM CURRENT PERIODICALS

Low Cost Diets for Pregnancy and Lactation. By Bertha B. Edwards. *The Medical Woman's Journal* (Cincinnati) for June. " . . . workers interested in an integrated family health service are finding their approach to the nutritional progress of the entire family through opportunities to work with expectant parents and parents of very young children. For since the nutritional needs of the preschool, school, and adolescent child present a remarkable similarity to those of the pregnant or lactating mother, it stands to reason that the ability of the parents to understand the needs of the mother and infant in this respect and to provide for them will be reflected in the well-being of every other member of the family."

Patients without doctors—and doctors without patients! In California the answer seems to be health insurance. A clear and comprehensive article on the current action in California on health insurance and the resolution adopted by the House of Delegates of the California Medical Association is given in *California Weighs Health Insurance* by Mary Ross in the May, 1935, *Survey Graphic.*

Should We Vaccinate Against Infantile Paralysis? by Dr. William H. Park, in the May, 1935, number of *The Parents' Magazine*, is an informative and illuminating article on inoculation against this dreaded disease. Dr. Park tells of the progress and future hopes of the New York Health Department Bureau of Laboratories in its effort to perfect a poliomyelitis antitoxin to combat the disease.

The Government has realized its obligations to the "younger generation" in its Federal program, and John W. Studebaker, U. S. Commissioner of Education, in his radio address, *Government's Interest in Youth*, describes America's youth problem and what the government is doing to solve it. The address was printed in *School Life*, April, 1935, number.

• Winners in the Sixth Health Conservation Contest have been announced and 40 awards made as follows: Nine in New York State; 5 in California; 4 each in Connecticut and New Jersey; 3 each in Massachusetts, Michigan and Minnesota; one each in Florida, Hawaii, Illinois, Maryland, North Carolina, Ohio, Pennsylvania, Texas and Wisconsin. This annual contest was initiated by the U. S. Chamber of Commerce and the American Public Health Association for the purpose of interesting local chambers of commerce in community health problems and studying their own local health activities to see what progress has been made during the year toward the accepted standards of public health work and what changes would be necessary to bring about a more effective health program. Enrollment in these interchamber health contests has gradually increased as interest has spread. This year 214 cities entered representing 44 states, Hawaii and Alaska.

• Included in the awards made by the Social Work Publicity Council for Distinctive Interpretation in 1934-35 are three dealing with health—one a series of radio sketches, "The Health Hunters," broadcast by the New York State Department of Health, another, "Mothers' Day Program" of the Maternity Center Association of New York City, and the third a magazine article, "The Nervous Breakdown" which appeared in *Fortune* for March, 1935.

• The Leslie Dana Gold Medal, awarded annually for outstanding achievements in the prevention of blindness and the conservation of vision, will be presented this year to Dr. William H. Wilder of Chicago. Dr. Wilder was selected for this honor by the National Society for the Prevention of Blindness in coöperation with the St. Louis Society for the Blind.

• The Public Health Nursing Committee of the Health Council of the Community Chest of San Francisco has completed a survey of public health nursing in San Francisco. It was found that sixteen organizations furnish some form of home nursing service by nurses. During May, 1933, there were 19,371 services given during 14,000 home visits. Approximately 75 per cent of the nursing services are given by two organizations, the Department of Public Health and the Visiting Nurse Association.

Where two or more agencies visited the same family the reason was often one of coöperation, yet there was some unnecessary duplication.

The committee recommends:

1. That a permanent Public Health Nursing Committee be established within the Health Council to further integration and correlation of nursing service.

2. That the committee plan and direct an experiment in public health nursing service under centralized direction in a selected area, the experiment to include active participation of all public and private agencies furnishing nursing and correlated services.

• Approximately 30 ERA nurses in Indiana are getting ready to conduct Red Cross Home Hygiene and Care of the Sick classes in their communities as part of their summer programs. They attended a two-day Home Hygiene Institute at the Indianapolis Chapter Headquarters of the American Red Cross in the National Headquarters of the American Legion Building, Indianapolis, in April, conducted by Mrs. Charlotte Heilman, Assistant Director, American Red Cross Public Health Nursing and Home Hygiene, Washington, D. C.

• The five regional meetings of the Massachusetts Organization for Public Health Nursing were held in May in

Northampton, Worcester, Lawrence, Boston and Brockton. An experiment was tried this year of repeating one subject at each of the meetings. The subject selected was "A Prenatal Visit," largely because the State Department of Health is emphasizing this year maternity care and especially the value of good prenatal work. Miss Helen Peck, Chief Consultant, Division Child Welfare of the State Department of Health, introduced the subject at each meeting, and was followed by Miss McQuade, a consultant nurse from the Massachusetts Health Department. Each district provided a mother who was supposed to be pregnant and a small child of two or three years of age. The nurse enters an imaginative home and finds the mother and small child, who are supposed to have newly arrived in the community and to whom a neighbor has sent the nurse. The visit is entirely spontaneous and is supposed to be conducted exactly as it would be in a home, with the interruptions from the child and the unwillingness of the mother to talk much but also anxious to learn all that can be taught her.

• A new Board and Committee Members Organization has been formed in Ohio, the first meeting being held in Toledo in May during the annual convention of the Ohio nurses, at which the following officers were elected:

President, Grace S. Frost, President, Toledo District Nurse Association;

Vice-President, Louise McCune, President, the Columbus Instructive District Nursing Association;

Secretary, Mrs. Joseph S. Barker, Vice-President, Cincinnati Visiting Nurse Association;

Treasurer, Mrs. David K. Ford, President, Cleveland Visiting Nurse Association.

The Executive Board will consist of the officers and four other members selected by them to represent different districts of the state, with two nurses acting as *ex officio* members, one of whom will be the chairman of the state section on public health nursing. The object of the Organization as stated in the by-laws is the promotion of interest of laymen in the various aspects of community nursing. Miss McCune spoke on "A Board Member's Responsibility to Public Health Nursing in Ohio" and Miss Haupt of the N.O.P.H.N. on "The Contribution of Lay Participation to Public Health Nursing." The meeting was followed by a luncheon.

• Elaborate preparations are under way for a special program for the industrial nurses of Illinois at the annual convention of the Illinois State Nurses' Association in Danville, on September 26th.

• The State Board of Health of Florida is contemplating an institute for public health nurses to be held in Gainesville at the State University from August 26-30th. The tuition fee is $10, which will include tuition, board and room for the five days. For further information communicate with Ruth E. Mettinger, Director, Public Health Nursing, State Board of Health, Jacksonville, Florida.

• When the second expedition sailed recently for Matanuska, Alaska, to settle the Government farm colony there, a public health nurse was on board. She was Madeleine de Foras, a Red Cross nurse who will remain with the colony a year. This plan was made possible through an arrangement between the Federal Emergency Relief Administration and the National Headquarters of the Red Cross.

• The number of American cities reporting organized public recreation shot up from 1,036 to 2,190, employed leaders increased from 28,368 to 43,419, and expenditures mounted from $27,065,854 to $41,864,630 in 1934, according to the findings of the year book of the National Recreation Association. The expenditures last year were the largest by three and one-third millions ever recorded for community recreation.

APPOINTMENTS

Helen Reynolds, as Director, Visiting Nurse Association, San Francisco, Cal.

Margaret Taylor, Director, District Nursing Association, Portland, Me.

[*For other appointments see p.* 400]